FAMILY MEDICINE RESIDENCY (FMR) HANDBOOK – AY 2012/2013

(SUBSTITUTES FOR CIVILIAN RESIDENCY CONTRACT REQUIREMENT)

99TH MEDICAL GROUP (ACC)

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I. RESIDENCY OVERVIEW

A. PROGRAM GOALS AND OBJECTIVES

- **Purpose of USAF medical service:**

  According to AFI 41-117 (*Medical Service Officer Education*), dated 19 Oct 2011, educational programs must meet published standards and criteria of their discipline or specialty. The mission of the USAF medical service is to ensure maximum wartime readiness and combat capability by maintaining the health of Air Force personnel, providing health care to deployed military personnel, and by providing a peacetime health care delivery system for beneficiaries. The mission of the Nellis Family Medicine Residency is to provide world class instruction so graduate physicians can supply a personal medical home for patients from cradle-to-grave, whether deployed or in garrison.

- **Goals:**

  To produce COMPETENT and QUALIFIED physicians:
  The primary goal of the program is to produce highly qualified, board-eligible family physicians capable of providing continuing and comprehensive care to the individual and family as an integrated unit, in any military or civilian medical system. Graduates are capable of independent practice in the field of Family Medicine and recognize that our responsibility is not limited by sex, age, organ system, or disease process but is comprehensive delivery of medical care.

  To propagate our specialty through MENTORING:
  The program should cultivate mentors who particularly focus on medical students learning our specialty while helping them foster skills unique to Family Medicine that they can use in their future specialty. All instruction is performed in an environment that places the highest priority on patient safety and empathic care.

  To perform as LEADERS:
  Graduates will lead patient care and be able to assume responsibility for directing a team approach to health management. Emphasis will be placed on the integration of a body, mind, and spirit approach as well as promoting healthy family dynamics within the broad context of community health care. The goal is learning how to engage patients and help them utilize their resources to cope with an illness and injury.

- **Objectives:**

  Founded in the ACGME core competencies and The Future of Family Medicine: A Collaborative Project of the Family Medicine Community

  a. Precepting family physicians to create a broad-spectrum, *patient-centered medical home* which results in generative growth for each individual patient and family
  b. Promoting *patient ownership* of all military families enrolled to the panels of the Family Medicine Residency through continuous on-going relationships in the outpatient, inpatient and nursing home settings.
  c. Supervising through *mentoring relationships* with team chiefs, fellow residents, and medical students to support the individual and the specialty of Family Medicine
  d. Preparing residents to gain sufficient medical knowledge to *pass examination* by the American Board of Family Medicine
  e. Requiring *scholarly activity* and encouraging active participation in organizations which further life-long learning such as AAFP (American Academy of Family Physicians) and USAFP (Uniformed Services Academy of Family Physicians)

f. Creating a *conducive atmosphere* for academic, emotional and spiritual growth of the entire staff by balancing time spent between medicine and family life; supporting weekly Balint meetings for morale and stress relief as well as providing clear policies regarding resident fatigue.
g. Teaching family physicians to become educators of patients, their fellow health care workers, as well as curious, *self-directed learners* for their own identified needs; clinical curiosity is paramount.
h. Supporting *community and international medical experiences* including civilian and military humanitarian missions
i. Enriching resident and staff experiences by *partnering with civilian medical resources* at Sunrise hospital, University Medical Center, the VA, Silver Hills Health Care Center, and local physician offices.
j. Developing ethical physicians who consistently display *professionalism* and integrity, as they humanize the health care experience in the family context of problems.
k. Incorporating *evidence-based medicine* (EBM) concepts into their practice and self-directed learning to develop a natural command of medical complexity
l. Promoting *cost-effective* health care maintenance and disease *prevention* at all stages of the individual and family life cycle.
m. Learning key *military medicine* concepts of the USAF medical service such as readiness, family health initiative (FHI), use of physician extenders and expeditionary medicine.
n. Leading nurses, technicians, and other ancillary staff in *interdisciplinary team work*, as they handle stressful situations, deal with ambiguity, and interact with the system around them.
o. Leveraging electronic records (AHLTA) and population health *information technology* resources to document clear concise notes, code accurately to allow appropriate billing, and target health care delivery to high-risk disease management diagnoses.
p. Organize, interpret and advocate for the patient's needs when *coordinating consultant care* for empanelled patients

- **Assessment of Goals & Objectives**:

A 3 year program of advancing responsibility, privileges and independence has been developed. This program emphasizes inpatient medicine, block rotations, and weekly Family Medicine clinic in the PGY 1 year and supervisory experience with subspecialty/elective focus, longitudinal format and continuity OB/emergency medicine in the PGY 2 and PGY 3 years. Increasing emphasis is placed on ambulatory rotations as the resident progresses. Evaluation by peers, Family Medicine faculty and faculty from outside departments is used not only as an educational formative feedback tool, but also as a summative means of documenting the resident's progress towards staff level competence. Evaluation also serves to identify those residents who are in need of special assistance or remediation. National in-service training examinations and Family Medicine board examinations provide further documentation of performance relative to Family Medicine peers in other residency programs.

The residency environment includes a continuously evolving curriculum experience, which is under constant evaluation; evaluation informs curriculum to complete the residency assessment process. Residents are guided by monthly team chief sessions to monitor acquisition of appropriate knowledge, skills, attitudes, performance, and practical experience. As a group, the faculty discuss each resident's performance quarterly and provide feedback to the team chief to take back to the resident.

E*Value is our web based system to collect formative and summative evaluations, including 360 evals from peers, patients and ancillary staff. Every quarter, the faculty reviews every resident's progress as reported by their team chief/advisor. Every 6 mos, an Air Force form 494 is completed on each resident to satisfy by AF regulations and ACGME requirements. Additionally, every 12 mos an AF

Form 475 narrative training report is composed which summarizes performance and is used later for consideration of promotion to a higher officer rank. The faculty also account for In-Training Exam performance when making decisions for adding progressive responsibility. Specifically by year group the ***MILESTONE ACADEMIC PROMOTION criteria*** are as follows:

- PGY1 to PGY2 (includes supervisory role)- pass all rotations, maintain ACLS/BLS/PALS/NRP, pass Step 3, collective staff opinion that resident has sufficiently grown as a clinician to begin supervision of new interns.

- PGY2 to PGY3 - pass all rotations, maintain ACLS/BLS/PALS/NRP, obtain state medical license, have scholarly activity project approved, show real progress towards completion of scholarly project

- PGY3 to Graduation - pass all rotations, maintain ACLS/BLS/PALS/NRP, take Board Certification exam, complete scholarly activity project, complete 10+ continuity OB deliveries and 40+ deliveries overall, complete 1650+ outpatient FM center visits

- **Required Support of Goals & Objectives**:

  The 99th MDG provides education of physician residents, dentists, nurse anesthetists, clinical nurses and medical technicians. It receives support and funding for training from the Medical Group Commander, 99th Air Base Wing Commander, Air Force Combat Command, and the Air Force Surgeon General's office. Per AFI 41-117 Section 1.42, "in the event of a reduction or closure of a program, the residents will be allowed to complete their education or will be assisted in enrolling in an ACGME accredited program in which they can continue their education."

B. WORK SCHEDULES

In accordance with the Accreditation Council for Graduate Medical Education (ACGME), the following guidance is provided for house staff/resident work schedules.

C. DUTY HOURS

- Regular daytime duty hours include M-F 0700-1630 (0600-1900hrs for inpatient rotations). This does not include call, night float or holidays/family days. Residents will be expected to stay until the end of each duty day unless they are doing shift work, released by the attending early, or are exceeding 80 hr work week rules (as below).
- Weekend Call hours: times will vary depending on which rotation is involved. Expect to round at least one weekend day on inpatient.
- Holidays and Family days: Residents on ambulatory rotations will have the day off, like a weekend day. Residents on inpatient rotations will work as if the day was a routine business week day.
- Work weeks are not to exceed 80 hrs/wk on average over a 4 week period. If this is occurring, immediately notify the service liaison and the Program Director. **Work hour violations will NEVER be tolerated!!** Explicit permission is given to break ACGME work hour limits to complete a continuity OB delivery, care for a sick/dying patient, or complete a special procedure. The PD must be notified via E=Value.
- No shift shall exceed 24 continuous hours. After 24 hrs, regardless of total length of shift, no new patients, ER evaluations or admissions are to be initiated. It is permissible to care for pts after the 24 hr time period has passed (e.g. humanistic reasons, unique learning opportunities, and continuity OB patients). It is the RESIDENT'S responsibility to arrange for coverage of ongoing pt

issues and assure that patient care is not compromised **prior** to leaving the hospital. PGY-1s may work 16 hrs maximum per shift.

- On average one 24-hour period per week or 4 days per block is required away from patient care.

- All Residents are REQUIRED to have 8 hours off between work shifts (days, nights or calls). 10 Hours is highly encouraged. Circumstances that require return-to-hospital activities with fewer than eight hours away from the hospital by residents must be monitored by the program director; therefore, residents will document these rare occurrences in E*Value and provide justification in the comments. PGY-2 and PGY-3 residents must have at least 14 hours free of duty after 24+ hours of in-house duty. PGY-2 and PGY-3 residents must be scheduled for in-house call no more frequently than every 3rd night (when averaged over a four-week period); PGY-1 residents do NOT take overnight call.

www.acgme.org

Under the 2011 Common Program standards, continuous duty hours for PGY-1 residents must not exceed 16 hours per shift or 80 hours per week, averaged over 4 weeks. More senior trainees may be scheduled for a maximum of 24 hours of continuous work in the teaching setting, with an additional 4 hours permitted for handing off patients to another practitioner or, in unusual circumstances, remaining with an acutely ill patient. Of note, studies have not shown that duty-hour limits have affected the quality and safety of inpatient care either positively or negatively, according to the ACGME. The goal of the ACGME's approach to duty hours is to foster a humanistic environment for GME that supports learning and the provision of excellent and safe patient care.

D. CONFERENCES

- **Balint:** Each residency year group will meet once a week in a group setting. These balint groups are moderated by the FMR behavioral medicine specialist. They are designed to help residents cope with the stressors of residency while maturing into a family physician and teach behavioral medicine concepts. Attendance at these meetings is **mandatory**. Residents are not to be interrupted for any reason except for true patient emergencies or continuity OB deliveries.

- **Team Chief:** The Family Medicine Residency is organized into teams for administrative and practice management purposes. The faculty team chief is responsible for meeting with residents on a monthly basis throughout the academic year. The purpose of these meetings is to keep track of academic progress, oversee social/mental health status and assure appropriate documentation of performed procedures. The team chief is responsible for mediating resident problems on individual rotations.

- **Morning Report:** M-F 0715-0800 in the FMR lecture hall/conference room. All Family Medicine residents not on inpatient rotations are **required** to attend.
- **Grand Rounds Noon Conference:** Tues 1215-1300 in the FMR conference room. All Family Medicine residents are **required** to attend.
- **Theme Day Teaching Conference:** 4th Monday 1230-1630 in the FMR Lecture Hall. All Family Medicine residents are **required** to attend. Other Mon afternoons are reserved for chart completion, MEB completion, home visits, nursing home visits, scholarly activity project work and other administrative responsibilities when on outpatient rotations.
- **Readiness training:** Held the 2nd Thursday morning of each month. All personnel not on inpatient duty or working with other services on outpatient rotations are required to attend.

- **Commander's Call:** Held on a monthly basis or as deemed necessary by the Medical Group Commander. All residents are **required** to attend commander's call. **This is not optional**. Residents involved in emergent patient care situations may be excused if coordinated with the Program Director
- **Prostaff:** All PGY-3 residents are **expected** to attend Professional Staff meetings, the 4th Thursday am of each month. PGY-1 and PGY-2 residents are **encouraged** to attend meetings when rotation responsibilities allow.

If a resident is unable to attend a conference, it is the resident's responsibility to inform the roll taker of the reason for absence. Excusable absences include post call, emergency patient transfers to outside facilities, procedures requiring resident attendance, leave, and TDY. Excused absences are not counted for or against resident attendance records. If 80% attendance is not achieved, Leave / TDY privileges may be withheld.

E. RESIDENT CALL POLICY

- **PGY-1 overnight call is not allowed for MOFMC rotations or inpatient services.** Residents on inpatient rotations will be available at 0600 the following morning to pick up any new patients and write admission H+Ps. PGY-2 Residents will cover inpatient call overnight on Sundays. PGY-2 and PGY-3s will split night float duties.
- An honest attempt will be made to schedule an equal amount of call when working at downtown rotations. Disputes regarding call should be brought to the attention of the call scheduler. Any continued disagreement should be taken up the chain of command which begins with the Chief residents.
- To care for our population we offer after-hours phone advice; a call service will notify you via beeper.
- **OB call responsibilities:**
    - Manage the labor deck with assistance from OB staff for all OB patients on L&D
    - Precept **all** patients and plans with staff
    - Assist with all C-sections
    - Evaluate all OB patients in the ER with staff obstetrician when possible

II. FAMILY MEDICINE RESIDENT RESPONSIBILITIES:

Being a Family Medicine Physician involves continuity of care for our empanelled patients which will be emphasized throughout the residency program. Beyond your scheduled core rotations, there will be additional responsibilities and items that need to be accomplished on a daily basis.

A. CLINIC SCHEDULE AND PANEL:

PGY-1:	one half day of clinic/wk	100 continuity pts
PGY-2:	three half days of clinic/wk. **May** include acute clinic	250 continuity pts
PGY-3:	four to five half days of clinic/wk. including acute clinic	350 continuity pts

B. CONSULTANT GUIDELINES:

The morning consultant will cover from 0715 to 1200. The afternoon consultant will cover from 1300 until the last resident patient has left the clinic.

A second consultant is scheduled when there are ≥ 4 residents in clinic. They will be the primary consultant for the PGY-3 residents and will act as backup when the first consultant is unavailable. Consultants will sit in the consult room.

C. PRIMARY CARE TEAMS:

Each team is empanelled ~1050 patients and consists of 1 faculty member, 1 PGY-3, 1 PGY-2, and 1 PGY-1 (structure may vary at the discretion of the program director). The team covers continuity of care for private OB patients, telephone consults, and lab results when members of the team are on leave/TDY or away rotations. Therefore it is critical to communicate this coverage with your support staff; you must designate your coverage surrogate in Outlook "out of office assistant" and post a note over your physical mailbox.

D. TELEPHONE CONSULTS:

All telephone consults should be addressed as soon as possible. At least one attempt per day should be made to contact the patient and documented within AHLTA. PGY-1 residents are expected to return all telephone consults personally. PGY-2 and PGY-3 residents may utilize their 4A's, 4N's and nurses to assist with call backs.

E. MAILBOXES:

Each resident has a designated mailbox in the resident room. It is important to check this at least once per day to ensure all items are handled promptly.

F. CLINIC RECORDS REVIEW:

All PGY-1 and PGY-2 resident charts must be marked for co-signature in AHLTA upon completion. This includes outpt notes and TCONs. The cosigning faculty will be the consultant for the **current** clinic day, and all notes must be completed by 1630. Each outpatient note should be written or dictated in the "Subjective, Objective, Assessment, Plan and Prevention" (SOAPP) format. Please ensure the problem list, procedures, allergies, prevention, and medications are updated in the AHLTA note. See the article in FPM by Crownover, B re: note construction, structure and synchronicity. http://www.aafp.org/fpm/2011/0700/p15.html

1) Clinic record reviews are an important part of the formal evaluation of Family Medicine residents. They serve to:

   a. Assess the completeness and quality of the documentation of medical care.

   b. Ensure the appropriate physical exam was conducted and documented.

   c. Review the proposed treatment plan ensuring it is appropriate and accurate.

   d. Ensure prevention strategies have been addressed.

2) The preceptor will review charts and will deliver written feedback via "On the Fly" E*value generated e-mail. It is imperative that the resident physician correct the identified discrepancy as soon as possible, and acknowledge receipt to the preceptor.

   a. At the monthly team chief/resident conferences, the residents' chart work will be discussed. Staff will review several of the resident's records and note comments by other staff in preparation for this interview.

3) Formal audits. Formal clinic record audits will be conducted at faculty discretion as follows:

   a. Staff will formulate a pool of diagnoses or problems that are subject to audit, based on demonstrated difficulty with certain areas.

   b. A staff physician, nurse or PGY-3 will audit a representative sample of charts for the problem and criteria he/she has chosen.

G. AUTOMATED DATA COLLECTION:

Every outpatient encounter must have proper E&M coding. The medical group has professional coders who review/audit assigned codes, but it remains the responsibility of the physician to assign the initial code within the disposition section of the AHLTA note. Anticipate overriding the suggested code in AHLTA often. If the physician disagrees with the coder, this can be a valuable opportunity to discuss the note with the coder and fine-tune the code. Residents should code all telephone consults as well.

H. HOME VISITS:

Residents are required to make ≥ 2 house calls on empanelled Family Medicine patients. This can be arranged with the team chief, the nurse case manager, or the behavioral scientist. Write-up forms are available on E*value. Visits may occur during lunch hour, Monday afternoons or after hours. You are encouraged to select more challenging patients, in which the home environment may enable you better formulate a plan of care. Once completed, the home visit should be documented in AHLTA and a procedure count inputted in E*Value.

I. VIDEO RECORDING POLICY:

Video recording may be used as an educational tool for Family Medicine training. During the three-year residency, each resident and team chief may have the opportunity to use this tool to evaluate his/her patient care, professionalism, interpersonal and communication skills. If no access to video recording is available, then faculty will directly observe residents in clinic using a mini-Cx form.

- If video is used, the Director of Behavioral Sciences and the Team Chief review recordings with the resident, usually on the day that they are performed.

- Residents should complete six video recorded interviews and/or mini-CX forms during their residency.
- Time will be set-aside in the Family Medicine Clinic schedule or the Simulation Center for recording.
- The staff reviewer will complete a medical Interview Skills Checklist in E*value.
- Informed consent (DD form 2830) will be obtained from all real patients.

J. PROCEDURE DOCUMENTATION:

The documentation of procedures and experiences serves as the basis for the credentialing process. Residents are required to document all procedures and services necessary for credentialing using the web-based E*value system. Interim documentation of OB procedures while working on a busy labor and delivery deck will take place on a pocket card distributed prior to the rotation.

K. SOCIAL WORKER:

There is a full-time clinical Social Worker assigned to the Family Medicine Department. You will interact with the Social Worker on several levels: (1) During your video recording sessions in the outpatient clinic; (2) during Balint; (3) when you have patients who may need psychiatric or social help; (4) while seeing patients conjointly; (5) during PGY-2 rotation; and (6) for your own personal issues, as needed. Each of these individuals or families may be referred to the Social Worker via direct or coordinated consultation.

L. REASSIGNMENT OF PRIMARY CARE MANAGER OR DISENROLLMENT:

From time to time you will encounter challenging or difficult patients. As part of residency training, residents will be asked to remain involved in the continuing care of these patients. On rare occasions, it is in the best interest of all parties for a patient or family to be transferred to another provider within the clinic or to another clinic entirely. The team chief and, if necessary, the program director are authorized to evaluate and make decisions concerning the best interest of the patients. A resident should not decrease his/her empanelment without the approval of his/her team chief and coordination through the clinic Group Practice Manager.

M. INPATIENT CONTINUITY ROUNDS:

All residents are expected to make **daily** continuity rounds on their Family Medicine patients who are hospitalized on any service in the hospital. All residents are expected to maintain close communication with the inpatient team to remain integrally involved in the patient's care. All residents are responsible for their obstetric and prenatal patients. Residents may manage their own Family Medicine patients with the supervision of the staff attending if they arrange this with the inpatient team.

III. ROTATIONS OVERVIEW

On the first day of the rotation, the Department Coordinator/Liaison will sit down with the incoming resident and discuss the responsibilities outlined in the rotational goals and objectives, plus any changes, additions or deletions. The attending should discuss individual expectations from the resident. At the midpoint of the rotation, a feedback session will be performed with an overview of the resident's strengths or weaknesses; if the attending fails to initiate mid-point feedback, it is the responsibility of the resident to request feedback. (If feedback is still not provided mid-point, the resident will notify the Program Director.) Any below average ratings should be discussed at this point and plans for remedial action should be made. The Program Director and Team Chief should also be advised of any such deficiencies and/or progress in correcting these deficiencies. No resident should be surprised by a below average standing at the end of the rotation. Residents will be graded by their level of performance on a progressive Likert system. Please see **attachment 1** for a sample instruction regarding resident grading.

A. ROTATION ATTENDANCE

1) No rotation will be less than 2 weeks long.

2) An "away" rotation is defined as any rotation where the resident is unable to perform FMR continuity clinic. Residency Review Committee (RC) requirements prohibit more than 12 weeks per academic year away from the resident's continuity clinic, and more than 8 weeks for any single absence.www.acgme.org. At least 4 weeks must separate away rotations.

3) Leave is allowed on electives, longitudinal rotations, and as designated on the 3-year master rotation schedule.

4) The residency coordinator will provide the rotation director with your schedule in advance. This will allow the rotation director to know which days you will be a guest in their dept. Any changes must be coordinated with our residency coordinator.

5) If the attendance requirements are not met, the rotation will remain incomplete. If this is a required rotation, time will be taken from elective rotations to remediate the days missed or residency completion will be delayed. Up to one half of elective time, not to exceed 6 weeks, may be used to remediate deficient performance.

6) Call the Residency Coordinator or chief residents if you will not be able to attend your rotation.

B. SCHEDULED ROTATION OUTLINE (See Attachment 2)

C. INPATIENT MEDICINE RESPONSIBILITIES (See Attachment 3)

D. OBSTETRICS UNIQUE INFORMATION:

1) CONTINUITY PROGRAM:

- CONTINUITY patients refers to private OB patients; they are required for graduation and represent a vital component when learning continuity of care. CONTINUITYs attend OB orientation and are recruited to the FMR program. They are assigned to residents on a rotating basis.
- If a patient in a resident's panel becomes pregnant, then that resident will follow her as a CONTINUITY if the pregnancy is low risk. Despite who is next in line for a patient, the PCM assigned to that patient will carry that patient as a CONTINUITY.

- A **minimum** number of 10 continuity deliveries are required for graduation. The FM RC policy as of June 2010 requires residents to see CONTINUITY patients at least twice prior to labor, deliver the patient **and follow them postpartum in house**, in order to count as CONTINUITY. To count ANY delivery, the resident should be the primary physician performing the delivery or acting as 1st assistant "getting your hands dirty" during the delivery of the infant.

  a) **PGY-1:** Residents may receive 1 new CONTINUITY/month after OB rotation.
     - 100% of Continuity pts must be precepted face-to-face with a staff BEFORE the pt is released from clinic.
     - If a patient from the resident's panel becomes pregnant prior to the completion of the required OB rotation, they may follow that patient as a CONTINUITY. This is the only exception to this rule.

  b) **PGY-2/PGY-3:** Residents will receive up to 2 new Continuity pts/month until Sept of PGY3 yr.
     - 100% of Continuity pts must be precepted with a staff BEFORE the end of the day.
     - If a CONTINUITY is due after the graduation of a PGY-3, all efforts will be made to reassign the patient to a PGY-1 or PGY-2 resident long before her delivery date. Transfer must be approved by all residents involved and the team chief.
     - Continuity pts will be followed solely by the assigned resident as much as possible. In the event a resident is on leave or TDY, coverage for the CONTINUITY MUST be pre-arranged.
     - The delivery of Continuity pts will be performed by the assigned resident. A CONTINUITY delivery will take precedence over the resident's current rotation except away rotations (unless coordinated and nondisruptive). ALL efforts should be made to attend a CONTINUITY delivery.
     - Continuity pts will receive prenatal care through the Family Medicine Department. The entire family of a CONTINUITY should be incorporated into the resident's panel in order to promote continuity of care. This is accomplished with the help of the Group Practice manager, and program director if necessary.
     - Postpartum and nursery care are the responsibility of the primary CONTINUITY physician.

2) MANAGEMENT OF COMPLICATED OBSTETRICAL PATIENTS BY FM DOCTORS:

If an obstetric patient being followed by a resident or staff physician becomes complicated, consultation with the either a FM/OB or the Obstetric Department is mandatory. Based on the diagnosis, a one-time consult will be performed and the patient will return to FMR or be transferred to the OB clinic.

a) Conditions Requiring Transfer of Care to OB (but residents may still co-manage with OB):

-GDM A2 and above
-Multiple gestation
-PPROM < 34 wks
-Recurrent preterm labor
-Severe pre-ecclampsia
-PMH includes autoimmune disease, severe renal/cardiac disease or hemoglobinopathy
-C-section requiring condition**

- a resident may follow elective repeat C-section patients as long as they are present at the delivery. C-sections may be performed by a credentialed FM staff.

b) Conditions Requiring One-time Consultation with FM/OB, OB or Perinatology/MFM

Abnormal Quad screen
AMA
Chronic HTN on medications
Chronic or gestational proteinuria (>300 mg/day)
Duration 2nd Stage Labor > 2hrs, 3 hrs if epidural
Fetal anomaly detected
GDM A1
IUFD
Mild pre-ecclampsia
Non-vertex position at 37 weeks
PPROM 34-36 weeks
Preterm labor – 1st episode
Unexplained third trimester bleeding

c) Conditions requiring informal FYI consultation, per DoD Guidance:

Epidural
Induction/Augmentation of labor

. **E. EVALUATIONS OF FACULTY AND ROTATIONS:**

At the completion of each rotation, each resident is required to submit a resident service evaluation of the faculty and rotation. **(See attachment 4)** These are reviewed at the residency education oversight group (REOG) and by the Program Director of the Family Medicine Residency. Resident comments are anonymously given to the services each quarter. If complaints are made, please give specific examples and send solutions for remedy of the problem. The Family Medicine staff is reviewed separately in an annual review. Residents are evaluated by faculty at the end of every rotation. This report will be reviewed and signed by the resident using the online evaluation system. All evaluations will be performed using E*value. Passwords will be coordinated with the residency coordinator.

IV. GRADUATION REQUIREMENTS AND LICENSURE

A. RESIDENCY REQUIREMENTS:

1. Annual Residency Review: An annual review of the residency curriculum is held each year in May on the 2nd Friday. All residents and staff are **required** to attend. The review is held at an off-site location on Friday and Saturday. Residents are excused from their services during the review.
2. Graduation Banquet: An annual banquet for Family Medicine residents is held in June on the last Saturday. All residents are **required** to attend. The banquet is held proximate to graduation. Residents are excused from their service from 1500 hours that day until the following morning.
3. Graduation Ceremony: The annual graduation ceremony occurs on the morning of 30 Jun (unless this falls on a weekend, then it will occur on the closest weekday). All PGY 1 and PGY 3 residents are **required** to attend. PGY 2 residents are encouraged to attend if duties permit. Graduating PGY 1 and PGY 3 residents are off service from 0800-1300 hours that day.

4. Resident retreats: Two separate retreats will occur. One will be in the fall following the in-service exam (all classes). The other will be in April on a Friday and Saturday (class specific). Residents are responsible for planning and funding. Residents are excused from their services during the retreats from 0800 hours on Friday to 1800 hours on Saturday.

5. Research Symposium: The Wednesday prior to Graduation (anywhere from 23-29 June). All PGY3 residents are **required** to attend and present their scholarly inquiry projects.

B. TESTING:

1. USMLE/COMLEX Step III: This is a **required** exam. This must be taken by 31 March of your PGY 1 year. Residents are given **ONE** travel day before and after the scheduled exam, only if a long distance test site is required, otherwise they may be dismissed the afternoon the day prior to testing. ***Testing fees are the responsibility of the resident***. The exam is taken while on permissive TDY. Permissive TDY paperwork must be obtained prior to leaving for the exam.. More information can be found by accessing the Internet sites: www.usmle.org and www.academyofosteopathy.org and http://www.nbome.org/contact.asp.

2. In-Training Exam: **Required** annual exam given nationwide to all Family Medicine residents in late October. The residency Behavioral Scientist or Residency Coordinator proctors the examination. This test bears close resemblance to the American Board of Family Medicine Certification examination taken after completion of the residency. Scores are used for program and self-evaluation; although, they usually do not directly affect resident advancement, they may be taken into consideration if part of an overall pattern of deficient performance. **Residents who receive less than 30th percentile will be placed on academic notice and given an education plan.** In training exam questions books are returned to the taker after the exam is administered. Sample questions are available from the senior residents or faculty. Remedial instruction may be required for low scores.

3. Family Medicine Board Certification: Computer based exam administered by the American Board of Family Medicine. See www.theabfm.org for application, fees and testing sites**.** Fees are usually paid (1st attempt only) while still enrolled in the program. All residents on track to graduate in June will take the exam in April of their PGY-3 year.

C. RESEARCH AND SCHOLARLY ACTIVITY PROJECTS:

Residents are required to complete a research project or scholarly activity project to be presented to the residency prior to graduation. The form of research is expected to be 1) an original research subject with observations, literature review, hypotheses, research design, data collection, statistical analysis, and conclusions formulated by the residents themselves, 2) residents may select a combination of a) case report submitted for presentation at USAFP (Uniformed Services Academy of Family Physicians annual conference) plus b) FPIN clinical inquiry coauthored with a staff physician, or 3) an Area of Concentration 200 hr project designed by the resident. FPIN inquiries (Family Physician Inquiry Network) are published in Journal of Family Practice, American Family Physician or Evidence Based Practice. In addition to submission to USAFP, case reports may optionally be submitted for written publication; case reports are often published by the Journal of the American Board of Family Medicine (www.jabfm.org) and Southern Medical Journal.

In the PGY-1 year, the residents will attend a research conference. The team chief and research coordinator will help the resident determine the best question to study and aid the resident in the development and implementation of the research project or scholarly activity. Research time is available and will be scheduled and monitored by the research coordinator and team chief. Study

start and end dates should be agreed upon by the resident and research coordinator. The end date should not extend beyond winter of the third year. Given this schedule, each third year resident is encouraged to present their study at any of the spring scientific assemblies, especially USAFP. TDY funding will be prioritized accordingly. All residents will present their research no later than the scheduled annual department research symposium in the spring of the PGY-3 year.

(See Attachment 7 for additional details on scholarly activity requirements)

D. LICENSURE:

PGY-2 residents must hold an **unrestricted** state license by the end of December of their PGY-2 year. Residents should apply for licensure no later than 1 Aug of the PGY-2 year. (Residents must be licensed to apply for the Family Medicine Board Certification examination, and to comply with AF regulation.) AF Personnel Center requires tracking of all PG-2 licensing efforts and forwards reports to the AF Surgeon General's office.

E. CREDENTIALING GUIDELINES:

1. Residents must perform the minimum number of procedures (if designated) and show competency in order to be credentialed as a provider practicing independently after residency. A resident's procedural skills are monitored by faculty from all departments. The resident's skill in performing the procedure is then graded by the faculty member using the E*value system. This allows residents to be identified who need additional experience prior to being granted privileges. There may be an instance where a resident is proficient at a portion of the procedure. The resident may place an addendum on the AF Form 2816 requesting specific solo privileges only in the proficient portions of the procedure.
2. Privileges will not be granted if the minimum requirement is not documented appropriately.
3. Prior to graduation from the residency, each resident will submit an application for credentials to the program director. Since documentation of supervised procedures is necessary to justify certain credentialing, it is incumbent on each resident to maintain a procedure log. All procedures should be documented using E*value. Please refer to the E*value procedures list to see those requiring documentation.
4. Documentation is required to establish the level of skill acquired by the resident, to document the level of supervision required, to make this information available to the attending staff responsible for supervision and to nursing and technical staff who will be assisting the resident in performing the procedure. For hospital-wide access, this is maintained on E*value. If you feel you have been given solo privileges and it is not on E*value, please bring your documentation to the Program Director or Program Coordinator to update.
5. Procedure tracking aids the Residency Director in determining the scope of skills and procedures for which staff privileges will be recommended upon completion of residency training.
6. At all times, the resident is working under the supervision of an attending physician, and the ultimate responsibility for the care of the patient rests with that attending physician. As such, the attending physician responsible for the individual patient's care will decide the degree of supervised care delegated to the resident.
7. The levels of competency established will be as follows:
   - "Direct Supervision": The supervising physician is physically present with the resident and the patient.
   - "Indirect Supervision" is broken down into two levels:

- "Direct Supervision Immediately Available": The supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide direct supervision.
- "Direct Supervision Available": The supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision.

• "Oversight": The supervising physician is available to review procedures and encounters and to offer feedback after care is delivered.

See **attachment 5** for a full list of procedures.

V. MILITARY ISSUES:

A. ADMINISTRATIVE DUTIES:

As an Air Force officer, you will be asked to attend briefings or perform designated computer assisted learning for annual training requirements. These tasks are required and will need to be performed promptly. Any problems completing these tasks should be addressed with the team chief. HOPS is the primary trng database for 99 MDG—recommend you set HOPS as home page on internet browser.

B. WEAR OF UNIFORM:

- For further guidance please refer to AFI 36-2903.
- It is mandatory that all active duty personnel arrive for duty in uniform of the day, (UOD) regardless of arrival time. Exception: Personnel participating in mandatory PT sessions may arrive in PT gear if showering and changing within the facility. Wear of the uniform is required base-wide for all military activities not related to direct patient care (do NOT go across base in scrubs!). The standard duty uniform for all Air Base Wing personnel are as follows:

    a. Monday—Short sleeve blue shirt, open collar
    b. Tuesday thru Sunday– ABUs
    c. Military Recall – ABUs

- No Hat/No Salute Areas. Although some medical groups have passage ways with no hat/no salute zones, ALL outdoors areas around MOFMC require salutes and hats except the outdoor patio dining area at the cafeteria.
- Surgical Scrubs.

    i. Surgical scrubs are designed as personal protective equipment to protect yourself and the patient. Scrubs are not personal property and will not be worn/taken outside the facility. Exceptions to this will be approved by 99 MDG/CC only.

    ii. Surgical scrubs may be worn while engaged in clinical scenarios wherein dirt/patient contamination is possible. Squadron CCs are responsible for approval of scrub wear and enforcement of this policy.

iii. Scrub Wear Outside of the Duty Section.

1. Scrubs may be worn outside of the duty section, with a cover or lab coat as long as they are clean and presentable. Masks and surgical shoe covers must be removed when leaving the immediate OR/L&D work areas. OR, L&D, MSU, ICU, anesthesia/OR offices and break room are considered immediate work area.
2. Scrubs may not be worn outside the hospital building at all.

iv. Identification. When wearing a scrub shirt without physician's white coat, within the duty section, the hospital identification badge must be worn. If wear of the ID badge limits patient care or endangers patients, then the badge may be kept on the wearer, but not necessarily clipped to the outer scrub. Every member of the MDG must wear and have the ID badge immediately available. In addition, blue uniform name tags with shiny rank positioned above them must also be worn on the right side of the chest. The hospital badge alone is not sufficient for name tag use.

C. RANDOM DRUG SCREENS:

- Notification for random urinalysis drug screens may occur. When notification takes place, it is considered a mandatory formation and must be carried out promptly. Report to the CSS (orderly room). Bring your military identification card. If providing patient care at the time of notification, inform your supervisor to assist with patient coverage. **Residents are not exempt** from severe military disciplinary actions if they are late for giving a urine sample. **YOU MUST GO!!!!!!!!!!!!!**

D. ELECTRONIC INFORMATION:

- CHCS, Essentris and AHLTA - Residents are taught how to use CHCS during inprocessing to the medical group. AHLTA is the military oupt EMR system and will be used to generate all clinic notes, telephone consults, review new laboratory and radiology results, and order entry. Use Essentris for inpatient documentation.
- Microsoft Outlook is the "official" software used for military e-mail. Residents are encouraged to check Outlook messages at least once per day. This system will be used for all "official" military communication. All internet activity is monitored. If an illegal site is accessed the Info Systems department **will be alerted**. Computers should never be used to for any reason that might bring discredit to the Air Force. Always assume your commander is looking over your shoulder when surfing the net…seriously.

E. RECALLS:

- As part of Nellis' Readiness mission, residents are subject to recalls. Recalls may present in different forms. Telephone recalls require the relay of critical information via telephone to those colleagues below your name on the recall roster. If a recall message requires the resident to report for duty then the resident should make their way to the hospital **ASAP.** (This means sign in within one hour if living off base, 1/2 hour if living on base). Residents will not be required to participate in all MDG exercises. Participation will be decided upon by the program director. Residents must maintain a current recall roster and should keep it readily available at all times. Please ensure the clinic NCOIC has your current contact information.

F. HOSPITAL DISASTER TRAINING:

- The second Thursday morning of each month is declared "readiness training day." Residents will be required to participate in the disaster training or exercise as directed by the hospital or Wing Commander.
- Disaster Plan: The Family Medicine Clinic is responsible for supporting the hospital disaster plan. Your team chief will assign you to a team. Disaster exercises and recalls will occur throughout the year. Disaster training will occur during readiness training days.

G. BENEFITS:

- **PAY:** Non-prior service physicians will start residency as a captain with zero years service for pay purposes, which provides more than adequate financial support to fulfill educational responsibilities. PGY-1 residents receive a $100 per month bonus. Upon completion of internship, PGY-2 and PGY-3 residents receive a $416 per month bonus. Residents who are prior active duty will be paid according to their current rank. Air Force pay scales may be viewed at. http://www.dfas.mil/militarymembers/payentitlements/militarypaytables.html. Remember malpractice liability for scope of practice issues is covered under US law by the Feres Doctrine.

H. LEAVE:

- All Air Force members accrue 2.5 days of leave per month. The ACGME requirements permit a maximum of 30 days of non-educational absence from the program each academic year. This includes leave, sick leave, maternity leave, family or emergency leave, and house hunting or PCS-related leave. No more than one week of leave may be taken at one time, without a waiver from the program director. Two leave periods may not be consecutive, and at least one month must separate any periods of leave of one week duration each. In order to take leave on a rotation you must be on a leave eligible rotation and have spent at least two weeks in that rotation during the year. Leave from residency does not accumulate from one year to another. However, residents do continue to accumulate Air Force leave that may be utilized after graduation from residency. Residents cannot reduce the total time required for residency (36 calendar months) by relinquishing vacation time. Per AFI 41-117, Para 3.8.1 the following leave amounts are authorized: http://www.e-publishing.af.mil/shared/media/epubs/AFI41-117.pdf
- PGY-1 residents may take 2 weeks of leave. Ten working days and four weekend days are allowed for use in leave status.
- PGY-2 residents may take 3 weeks of leave. Fifteen working days and six weekend days are allowed for use in leave status. PGY-2 residents may also receive one week of paid educational TDY. See AFI 51-603 for details on educational TDYs.
- PGY-3 residents may take 4 weeks of leave. Twenty working days and eight weekend days are allowed for use in leave status. These 4 weeks include any time spent for househunting while on permissive TDY. PGY-3 residents may also receive one additional week of educational TDY.
- Local policy: Residents do not need to be on leave for non-duty times (weekends / holidays) if: 1) the resident is back for duty on time, 2) the resident was not scheduled for work (so residents must take leave if they do not want to be put on call), and 3) the resident drives out of the area to a location on a day trip. If a resident takes a flight out of the area over a weekend, the resident must be on leave. If a resident takes Friday off and remains in the local area, then the resident only needs to take leave for Friday. Remember this is highly variable. The wing commander can change policy to be more restrictive than the AFI.
- Maternity Leave Policy: Once pregnancy has been confirmed, pregnant residents will notify the Family Medicine Program Director and the Chief Residents. Efforts will be made to schedule the most demanding rotations earlier in the pregnancy. The rotation performed around the Estimated Date of delivery (EDD) will be one in which the resident is not essential for the service. The call

schedule will be arranged to have no call after 38 weeks (Gestational Age) and while on maternity leave. However, the resident is expected to make up call before or after this time so as not to cause a disadvantage to other residents currently in the program. The duration of maternity leave will be based on the written recommendation of the physician caring for the resident. Current USAF policy allows for 42 days of maternal convalescent leave. The resident may choose to have the entire 42 days of leave, but must realize that any time beyond 30 days in any academic year will result in an extension of training. The resident may, at the discretion of the Program Director, design a home study or reading "AWAY" elective that complies with the Family Medicine-Residency Review Committee's requirements, and does not include continuity FMR clinic. This can be done around the EDD or after delivery to minimize the time needed away from the residency. In this manner, residents will return to the residency after maternity leave without loss of training status. A resident should not be away from their continuity clinics for more than 8 weeks maximum at one time unless there will be an extension of residency training.

- Paternity Leave Policy: Current Air Force policy allows for 14 days of permissive TDY to be granted to fathers after delivery of a baby. This PTDY is not guaranteed and can be given or withheld at the discretion of the Squadron Commander. If a resident is granted Paternity Leave, the resident is expected to make up call before or after this time so as not to cause a disadvantage to other residents currently in the program. The resident may choose to have the entire 14 days of PTDY, but must realize that any time beyond 30 days in any academic year is not permitted.

I. SCHEDULING LEAVE / TDY:

- The residency leave / TDY request form must be completed prior to the clinic schedule and **at least 2 months** prior to the planned month of TDY or leave. The form must be completed and signatures obtained in order on the form. The program director (or delegated team chief) ultimately approves the leave request in the AF leaveweb site (https://leave.nellis.af.mil/leaveweb/LeaveWeb.aspx), only after receiving a completed leave checklist.
- TDY / CME approval forms must be submitted with justification comments. A copy of conference information must be made available to the reviewing officer as soon as possible, in order for approval of funds.
- If dates for leave change or if the leave is canceled, this must be made known to the Residency Coordinator, Chief Resident, Rotation Supervisor, and Clinic Schedulers as soon as possible. Changes must also be updated in the Leaveweb system.
- Upon departure on your leave/TDY, you must ensure the following have been accomplished:
  - Appropriate paperwork (leave request, leave web, TDY forms) and HOPS current
  - Identification of a surrogate for T-CON's, new results, and OB coverage
  - Turned on the "out of office" reply on your outlook email account
  - Place a completed "Out of Office" form on your computer and mailbox
- Any disputes regarding proposed leave / TDY should be handled initially between the parties affected. If no solution can be reached, the Chief Resident will mediate the conflict. Further disputes will be brought to the attention of the Program Director for a final decision.
- Schedule Changes: Required clinic schedule changes are to be brought to the attention of the Chief Resident and Coordinator as soon as possible. These may include changes in TDY, leave, competing clinic duties, or inability to perform required training.

J. HOLIDAYS:

- The Air Force honors all federal holidays. Residents not on-call and on outpatient rotations are not required to report to work. Residents on inpatient services on holidays will coordinate with staff and the other residents on that service to provide continuity of care to hospitalized patients to include rounding and completion of daily notes.

K. MOONLIGHTING:

- Air Force policy prohibits moonlighting by physicians in training.

L. DUE PROCESS:

- Specifics regarding due process are available in AFI-41-117, Section 2.2 and determined by AF policy.

- The initial step is identification of a deficiency or problem. The resident receives verbal +/- written feedback or evaluation delineating the problem.
- If a rotation will require remediation, a written plan coordinated by the Team Chief between the program director and service liaison is presented to the resident for signature and placed in the resident's folio.
- A letter of academic notice may be used for serious deficiencies (knowledge, behavioral, professional or ethical). It will state the deficiency, actions required to correct the deficiency, remedial plan with responsibilities of staff outlined to assist resident, means of measuring progress, timeline, and supervisory oversight. This is to be signed by the PD and all parties involved. When the performance improves, removal of academic notice status is provided to the resident. The involved parties will sign acknowledging that academic notice has ended and the paperwork is placed in the resident's training folio.
- Academic probation is a more serious notification and if not remedied may result in delay of training graduation or termination from the program for which residents may file a grievance per AFI 41-117. Written deficiencies and plans are adhered to as noted above. Any resident on probationary status will be reported to HQ AFPC/DPAME and the state licensing board.
- If conditions which warranted probation are not corrected by the resident, termination may be recommended by the faculty. If so, the Director of Medical Education (DME) presents the termination recommendation to the MDG Commander for concurrence. After the CC approves the recommendation, the resident has 10 days to request a faculty board to rebut the recommendations. After a rebuttal board (if requested), the faculty board members forward their conclusions to the Commander for reconsideration. If the CC still approves of termination, AFPC is contacted for final approval authority.
- The DME is notified of residents who receive any probation or academic notice as reported to the Residency Education Oversight Group (REOG) committee. The REOG ultimately reports to the GME Committee (GMEC) which oversees all training programs at Nellis AFB.

M. IMPAIRED RESIDENTS:

- Our department is very sensitive to the demands of residency training and to the fact that not all residents are prepared for the rigors of this undertaking. Team chiefs need to be aware of residents who are having difficulty performing their residency tasks because of professional or personal problems. A clinical social worker who is assigned full-time to the Family Medicine department will confidentially aid the professional staff or assist with finding care off-base. Providers impaired due to

alcohol or pharmaceutical agents will be restricted immediately. Other situations will be assessed based upon the safety of patients and providers.

- Residents should immediately report any impaired supervisors or fellow residents to their Team Chief or the Program Director.

N. FITNESS

- Physical fitness is mandatory. The USAF requires that all members complete physical fitness testing twice each year. If you are not scheduled to do your PT test by July 15 of intern year, talk to your team chief. The test consists of a 1.5 mile timed run, 1 minute of timed push-ups, 1 minute of timed sit-ups, and waist measurement. A composite score is calculated (see the Fitness Management System in the Air Force Portal). You must score at least 75 to pass. Failure to pass will result in mandatory fitness training, disciplinary action by the commander, possible placement on Academic Probation for lack of professionalism, and even discharge from the Air Force. The Air Force takes fitness seriously!!!!!!!

VI. HOSPITAL MISCELLANEOUS

A. MEDICAL RECORD REVIEW:

- In an attempt to standardize documentation of supervision of the residents, the following guidelines for supervision of the residents are in place.
- An admission resident note is required for all patients admitted to the hospital team. The staff-attending physician must make an admission entry in Essentris within 24 hours of admission. If the patient is in the ICU, this should occur within 4 hours.
- Residency policy requires History and Physicals to be completed in Essentris.
- The method of documenting staff attendant's awareness of the resident's treatment of a patient is as follows: the staff attending may acknowledge his/her supervision by signing under the resident's progress notes at least once a day, stating "I have seen and evaluated the patient. I have discussed the management plan with the team and agree as outlined above."
- It is ultimately the attendant's responsibility to insure that the SF 522, Request for Administration of Anesthesia and for Performance of Operations and Other Procedures, is appropriately completed. Per AD/JA recommendation, a countersignature by the attending physician is not required when the staff physician played no active role in the preoperative counseling of patient.
- When a Family Medicine resident performs a procedure under the supervision of a staff physician, he/she documents adequate staff supervision by specifying the supervising physician's name in his/her procedure note.
- In order to document the attending physician's knowledge of the condition of the patient and of the care given to the patient, he/she is responsible for writing a progress note daily for a stable, long-term patient and more often as dictated by the condition of the patient.
- Documentation of chart review on outpatients seen by Family Medicine residents is the responsibility of the chief of each department.
- Residents are not responsible for a narrative summary report on patients for whom they have not significantly participated in care.
- Residents will not independently perform consultations. It is perfectly acceptable for residents to participate with the attending physician in the evaluation of patients of consultations. The

Consultation report may be completed by the residents; however, it must include comments by the attending physician and his/her signature.

- All entries in the medical record must be dated, timed and signed. Progress notes and orders must also include the date, time, and signature on the entry.

B. STAFF ATTENDING SIGNATURES:

- Staff attending signatures (written or electronic) are required on all H&Ps, dictated narrative summaries, handwritten discharge summaries, and operative reports.

C. INPATIENT RECORDS:

- Once each week, residents are to ensure inpatient records are completed. Prior to discharge, all patient's records are to be reviewed for an appropriate History and Physical, unsigned telephone/verbal orders, and completion of the discharge note.

D. DEATH CERTIFICATES:

- Death certificates are filled out at the time of the event. Any questions regarding death certificates or deaths after hours should be referred to the hospital Admission/Disposition clerk, who is available 24/7. MOFMCI 44-25 reviews organ donations.

E. INCIDENT REPORTS:

- The Quality Improvement Program is vigorously pursued in the Air Force and at the 99th Medical Group. One way for you, as a provider, to provide input into the Quality Improvement Program is the MOFMC Form 0-32 which is an Incident Report form available on every desktop as a distinct icon. The Incident Report is completed when a patient has fallen or been injured in some manner, medication errors occur, or when there are any unexpected occurrences that had the potential for an adverse patient effect. The Patient Safety Program Manager reads these reports. He/she then makes an assessment as to whether any hospital or personal liability may be active in a particular case. These reports should be filled out as soon as possible after the incident so that details of the incident are recorded accurately.

F. DNR ORDERS:

- Occasionally patients will require "Do Not Resuscitate" or "DNR" orders. A staff physician must write a note in the patient's progress notes stating that resuscitative possibilities have been discussed with the patient and his/her family. Both the patient and the staff physician should ideally sign this note. A staff physician must write all "DO NOT RESUSCITATE" orders, however, a resident may write a valid holding order to cover the DNR need until the staff can arrive to sign formally. After normal duty hours and on weekends, the Emergency Department staff physician may perform this function, but ideally the service's attending physician should perform it at the time of admission. DNR orders should be renewed after 72 hours. Further guidelines are outlined in MOFMCI 44-1, Chapter 4.

G. PHONE / VERBAL ORDERS:

- Phone orders may be given when necessary but are discouraged as a routine format for managing patient care. They must be signed within 24 hours in Essentris.

H. CONSULTATIONS:

- Routine consultations with other specialists can be requested via AHLTA or chart order. ASAP or Stat consults require verbal contact with the referral physician. The only exceptions are that AD patients/families may directly call MilitaryOneSource.com for Mental Health concerns ((800) 342-9647) or the Military & Family Life Consultant ((702) 715-9128); any patient may make an optometry appt directly with a TRICARE network provider.

I. REPORTABLE DISEASES:

- There is a list of disease processes (http://www.cdc.gov/ncphi/disss/nndss/phs/infdis.htm) that residents may come in contact with during residency which are considered a threat to the community. Because of the level of contagiousness or severity of illness that these diseases produce, they must be reported via an AHTLA consult to "public". Military Public Health is the office responsible for the collection and reporting of this information.

J. MEDICAL STATEMENTS:

- Patients frequently ask for written medical statements when an illness affects their job performance. Residents may compose these statements. More often, active duty troops will have their medical status defined on an AF 469 Profile, which is processed using the PIMR tracking program. Non active duty patients can also have a work/school excuse slip completed in the exam room documenting their status.

K. CALL ROOMS:

- Call rooms are located on the 2nd floor and will be shown during initial orientation. Another call room will be available for faculty in the FMR work area. Lab coat laundry service is available in the basement.

L. INFORMATION SYSTEMS:

- Computer Tablets- If issued, tablet computers must be returned upon graduation and maintained within the facility at all times during their use. Dragon Naturally Speaking may be used for voice recognition to complete notes on the Tablet.

M. DICTATION:

- **Dictation instructions are provided to every healthcare provider by the medical records department.** All clinic notes will be completed in AHLTA unless there are extenuating circumstances. Notes such as medical evaluation boards (MEBs) may be dictated using the approved format.
-

N. DINING FACILITIES:

- The hospital maintains a dining hall serving all meals daily. Meals brought from home or take-out delivery are also common practice. A 24-hour vendor operated snack bar and numerous facilities on base are available after hours.

Hours of Operation

Breakfast: 0630-0730, Monday - Friday
0700-0730, Weekends & Holidays
Lunch: 1100-1300, Monday - Friday
1130-1230, Weekends & Holidays
Dinner: 1630-1730, Monday - Friday
1700-1730Weekends & Holidays

O. DRUG REPRESENTATIVES:

- Though interactions with drug representatives are allowed, care must be taken to be both respectful, yet professionally critical with respect to their information. Their agenda will often not coincide with the best interests of the Air Force. Air Force instructions also dictate strict guidelines on gifts that may be received, typically less than $25 equivalent per year--this includes meals.

P. LIBRARY:

- Electronic media is the recommended source for medical information. Access to OVID, MD consult, UpToDate and several full texts are available thru the AF Virtual Library Knowledge Exchange (KX), which does not require a password if accessing from a .mil computer on base. Don't forget that Lexi drug database is free for download on your smart phone via the KX. https://kx.afms.mil/kxweb/dotmil/kj.do?functionalArea=VirtualLibrary

Q. PERSONAL HEALTH:

- Residents who are not on PRP/flying status will be asked to identify a physician in the Family Medicine Clinic who will act as your personal physician. This will usually be accomplished during the orientation month. **This physician should not be another resident physician, your team chief, or the Program Director.** In addition, all Air Force members require an annual periodic physical exam or a preventative health interview. Residents will be notified by a computer printout or e-mail message when this is due. Immunizations may also be required. Health care for you and your immediate family is provided by the USAF, without any annual copay.

R. UNIFORMED SERVICES ACADEMY OF FAMILY PHYSICIANS (USAFP):

- http://www.usafp.org/ This is our chapter of the American Academy of Family Physicians (AAFP) and we highly encourage all residents to become members of the USAFP. Per AAFP bylaws, membership in state chapters other than USAFP is not allowed. As an inducement, the USAFP will pay the dues of all PGY-1 residents. Afterwards, the responsibility belongs to the individual physician. Dues are currently $30 per year and include the monthly newsletter and monthly journal, "The American Family Physician." The final choice of membership is up to each individual and no educational or institutional prejudice will be tolerated. Resident applications are available at: www.aafp.org/residentapp or http://www.aafp.org/online/etc/medialib/aafp_org/documents/membership/apps/residentapp.Par.0001.File.tmp/Resident-08.pdf.

Attachment 1

TALKING PAPER FOR ON-LINE EVALUATIONS FOR NELLIS RESIDENTS

The on-line evaluation system we use is straight forward. When you are assigned an evaluation for a resident/staff you worked with, you will get an e-mail notification. This is usually done in advance, so you may see assignments before you compete the training period. Once the rotation is over, you will get e-mail reminders to complete the evaluation. The evaluations are point-and-click using a Likert scale. The nuts-and-bolts of filling out and submitting the evaluation should be self-explanatory. At the end there are free-text comment boxes and we all greatly appreciate specific formative statements about their performance, especially on areas they should work to improve.

We expect interns to receive rare 2s and mostly 3s for their rotations. We look at the Likert scale as a progression throughout residency, where a 4 or 5 means they are ready to practice as an attending physician without supervision.

Finally, a word about procedure evaluation by attendings. The residents submit procedures and staff will receive a notification that the resident submitted a procedure for review by e-mail. Staffs are not signing them off to practice this independently simply by reviewing, just acknowledging that they participated in the procedure enough to receive credit. They submit for independent performance status through a separate process, although staff are encouraged to put in a comment making that recommendation if warranted.

If you have any questions or have any problems, please contact us either by e-mail or calling at 702.653.2775.

Attachment 2- Rotation Schedule Outline

R1 Yr - one half day clinic per week; Balint Monday 1300-1400

Block 1	Block 2	Block 3	Block 4	Block 5	Block 6*	Blocks A+B	Block 7	Block 8	Block 9	Block 10 *	Block 11	Block 12	Blocks C+D*
MOFMC FM	MOFMC FM	MOFMC AF IM	MOFMC VA IM	MOFMC Nursery/ Peds Clinic	MOFMC OB Gyn Clinic	Research/ Inpatient/ Clinic	MOFMC OB Labor Deck	Elective/ Geriatrics	MOFMC Ortho/Gen Surgery*	MOFMC Gen Surgery	Sunrise Peds Ward	Sunrise OB Labor deck	Research/ Inpatient/ Clinic
AM conf	AM conf	AM conf	AM conf	No conf	No conf	AM conf	No conf	AM conf	AM conf Ortho only	No conf	Clinic Monday- AM AM conf Mon only		AM conf

R2 Year- Clinic 3x/wk; Trng/Research/QI/Nursing home/Clinic Mon PM; Balint Wed 1200-1300

Block 1	Block 2	Block 3	Block 4	Block 5 *	Block 6 *	Blocks A+B	Block 7	Block 8 *	Block 9 *	Block 10 *	Block 11	Block 12 *	Blocks C+D*
MOFMC FM	MOFMC Night Float / Elective	MOFMC Night Float/ Nephro	MOFMC Sports Med/Gyn	MOFMC Procedure FM Clinic	MOFMC Cards/ Pulm	Research/ Inpatient/ Clinic	Sunrise Nursery	MOFMC: Mental Health & LCSW	MOFMC: Derm & Endocrin	MOFMC: ENT & Ophth	MOFMC: Urology/ Selective	MOFMC Peds Clinic	Research/ Inpatient/ Clinic
			Sunrise Peds ED - 8 shifts over course of year (12 hrs each): 96 hours total										

R3 Year- Clinic 4x/wk; Trng/Research/QI/Nursing home/Clinic Mon PM; Balint Thurs 1200-1300

Block 1 *	Block 2	Block 3	Block 4 *	Block 5	Block 6 *	Blocks A+B	Block 7 *	Block 8*	Block 9*	Block 10 *	Block 11	Block 12	Blocks C+D*
MOFMC ED-12 shifts (10 hrs each)	MOFMC GI & FM inpt	MOFMC Derm* & Night Flt	Practice Mgt & Ldrship	MOFMC Neuro/ Selective	Elective	Elective	Elective	MOFMC Sports Med/ Ortho	MOFMC Peds Clinic	Procedure FM Clinic	FHI Experience /Comm. Med	Sunrise Trauma Surgery	Elective

Lettered holiday blocks 1 wk each - Christmas/New Year/Pregraduation

MOFMC: Mike O'Callaghan Federal Med Ctr, Nellis AFB
Sunrise: Sunrise Hospital, Las Vegas
VA: Veterans Admin Inpt services at MOFMC
AM conference: 0715-0800 in FMR
* leave eligible time

Last update: 9 Jun 12 -bc

Numbered blocks are 4 wks duration each

Blocks A-D: R1-clinic (1wk)/inpatient(1wk)/research(2wks)
R2-clinic (1wk)/inpatient(1wk)/research(2wks)
R3-elective

Dedicated half day research with research director monthly
-ALL residents
Selective- Pain, Rheum, Operational Med, Rad, VA ICU

Attachment 3

Inpatient Medicine Responsibilities

1. Inpatient Rotations

Welcome to the inpatient medicine rotation!! Each block will be 4 weeks of intense learning for your primary care hospitalized patients. The following is a list of guidelines and responsibilities, depending on your level of training. This list is in no way comprehensive, but it is a good starting place for you to learn the roles and responsibilities of a hospital provider. The VA, Internal Med and Family Med Staff are excited to work with you while caring for some of our sickest patients, and we will be available to you to answer any questions or guide patient care when needed.

Intern Responsibilities: 1) REPORT DATA 2) INTEGRATE DATA INTO DDX 3) MANAGE CONDITION

1. The intern is responsible for a complete history and physical to be written on every admitted patient. This includes a comprehensive assessment and plan which should address differential diagnoses for the acute issue, thorough treatment plan, and chronic illnesses.
2. The intern will write each daily SOAP note which should include reason for admission, 24 hour events, new test results, status of admitting diagnoses and treatment plans.
3. The intern, as the data master, should create a flow sheet of labs and ancillary studies for quick reference on each appropriate, more complex patient (your senior can help decide which patients would be considered appropriate).
4. Pre-rounding to formulate comprehensive plans for your patients is expected. Ask questions of your senior, and be sure you understand the reasons behind the decisions that are made on your patients. Strive to act as if your senior is only a consultant and you are running the case, especially as the year progresses.
5. As an intern, the bulk of your learning comes from your colleagues and seniors. It is strongly encouraged that you follow your senior as often as possible early on to see how they conduct patient interviews, consultant requests and attending interactions.
6. The intern is responsible for all discharges. Each patient should have a time and date for their hospital follow up appointment prior to leaving, unless an alternative is approved by staff. Plan for discharge when you admit, i.e. anticipate difficult placement patients and work with discharge planner early. It greatly helps if you define your admission endpoint (when the patient will be ready to leave) in your admission H+P (ex. last number in A/P can be "Disposition").
7. The intern must provide the patient's PCM with a discharge summary. This can be done by copying the discharge paperwork (if civilian PCM) or by ensuring the discharge summary is created in AHLTA. Most PCMs in FHC do not access Essentris.
8. The intern, along with their senior, must follow up on all tests ordered before leaving that day. If a test is not completed prior to leaving, night coverage should be made fully aware of the test and the implications that a result may have on the overnight plan.

Resident Responsibilities: EDUCATOR and TEAM LEADER

1. As a senior resident, you are responsible for the inter-workings of the team. Your attending should serve as an overseer and consultant, but it is your responsibility to assure that the day-to-day team interactions go smoothly and efficiently. If the intern does not have a plan for patient care, you should. If the intern does not have the lab results for the morning, you should. If the intern is unavailable to present a patient, it is expected that the resident knows the patient well enough to complete a full presentation at rounds. When the intern is unsure about why something was done, the team will look to the resident for clarification. This is a big responsibility, as this expects that the resident is able to efficiently do the intern's job plus their new job duties. If as the senior you become overwhelmed, you are expected to discuss this with your attending immediately. Patient safety is always first.

2. The senior is expected to be the first team member to evaluate any potential new admission and determine disposition. Presentations via phone to the attending may be done by the intern with senior coaching or preview. The senior is also responsible for hospital admission orders. These may be written by the intern if the senior is present for complete review. The phone calls to the attending notifying of new admissions can become the responsibility of the intern as the year progresses, but the senior should always oversee this process.
3. ALL CRITICAL labs or patient issues should be documented in the pt record.
4. The senior is responsible for notifying the attending of any significant change in patient status.
5. All hospitalized patients on the Adult team that require consultations with sub-specialists should be discussed in person by the senior with the consultant in question after approval from the staff attending.
6. The senior is responsible for full supervision of the intern. This includes but is not limited to pre-rounding with them, reading their daily SOAP notes, preparing them for AM report or rounds, assuring their duties are completed in a timely fashion (such as writing orders). One-on-one teaching can occur while evaluating new admissions with the intern as well.
7. Any hospitalized patient on another team who requests consultation should be evaluated promptly and discussed with the attending. The consultation note and daily follow-up notes are to be completed by the senior. It is important to determine our role as consultants (order writing or not), and this may differ with each patient on whom we are consulted.
8. An ICU summary/addendum of the day's events/discussions should be written (though this does not have to be in SOAP note form) before departure each evening.
9. The senior should check with the staff attending at the end of the day to review the day's occurrences and clarify any questions that may be predicted for the night float team. Be sure that results of tests ordered that AM are researched and available.
10. SBAR format should be used for handoffs – SITUATION, BACKGROUND, ASSESSMENT, RECS.

R: REPORTER (MS 1 and 2)
I: INTEGRATOR (MS 3 and 4)
M: MANAGER (Intern)
E: EDUCATOR (Senior Resident)

[RIME mnemonic was created by Col (ret) Lou Pangaro, Army Internist and USUHS professor. It is used by USUHS currently for teaching medical students.]

TRIGGER PROTOCOLS REQUIRING RESIDENTS TO CALL SUPERVISORS within 1 hr

- Patient Death or Suicide attempt
- Unexpected transfer or elevation to care (Ward to ICU)
- Unplanned intubation, cardiac resuscitation, pressor use or invasive procedure
- Significant neurological decline
- New consults from other services
- Evaluation for admission in Emergency Dept
- Signing out against medical advice (AMA)
- Initiation of restraints
- Patient or Family Request

NIGHTFLOAT EXPECTATIONS

The primary objectives for interns are to learn to critically evaluate and document thought process while caring for patients. Primary objective for seniors is to critically evaluate and care for patients AND practice being a staff. SO…interns can be expected to do UP to three H&P's for overnight admissions each. This is to ensure that they can show the ability to evaluate AND adequately document their thought process.

The night float PGY-2 or PGY-3 resident will write EITHER a resident admit note OR full H&P on admissions up to 6 patients. Anything over 6 patients will require a FULL H&P.

Resident admit notes (RAN) should contain:

- concise HPI
- key past medical history
- highly pertinent physical exam findings, labs and rads
- FULL and complete A/P section with a clearly documented thought process and plan
    - This is the MOST impt part of the note

Remember that time should be balanced between medical ward, labor and delivery and ICU. Given that deliveries are a key ACGME requirement, do not miss a delivery on your shift. IF necessary, call in your staff to care for a crashing medicine patient while you get a delivery.

Note Structure – SYNCHRONICITY

Family Practice Management

July/August 2011 Table of Contents

Structure and Synchronicity for Better Charting

Two key characteristics will help you to ensure that your notes communicate not only what you did, but also what you were thinking.

Brian Crownover, MD, FAAFP

Fam Pract Manag. 2011 Jul-Aug;18(4):15-17.

How many times have you read a medical note that does not make the selection of the diagnosis or treatment clear? Have you ever read your own notes after receiving notice of a malpractice suit and winced at the inconsistencies?

Poorly constructed medical notes are a widespread problem. I've seen it while reviewing the charts of medical students and residents to ensure that they met the standard of care and avoided malpractice risk. While most physicians document history and physical data with the required number of CPT elements, few clearly convey a line of reasoning that reveals their clinical thought process. A note that documents a detailed history and moderately complex decision making does not necessarily illuminate why certain decisions were reached or why a particular treatment was justified.

I wanted to find out where in the educational process students learned key documentation concepts, so I did some research that included informally querying medical students from multiple medical schools who were rotating at our residency. None of them could describe learning a formal structure for completing assessments and plans, which is consistent with a study that found only 4 percent of standardized encounters were accurately charted by medical students.[1] I also discovered that the 2010 United States Medical Licensing Examination clinical skills exam guide states that students are expected to present a list of differential diagnoses in order of likelihood along with desired evaluations, but no requirements existed for discussing the clinical rationale.[2]

As a result of these and other findings, I developed a formal framework, described in this article, to teach residents and students an appropriate way to construct their notes. The initial feedback has been highly positive.

Documenting a confirmed diagnosis

To begin, let's review what should be included when documenting a confirmed diagnosis. Generally, six elements are needed (see also "The structured note" summary).

1. New or established diagnosis. The first element overtly communicates to coders whether the diagnosis is new or established, since this helps to determine code selection.

2. Controlled or uncontrolled. The second element should communicate whether the status is controlled or uncontrolled, which also directly affects complexity and reimbursement.

3. Treatment goal. The treatment goal should be clearly stated. How can one justify the decision to refill, increase or decrease a medication if the desired benefit is undefined? For example, simply refilling albuterol for asthma may actually hurt the patient if he or she needed a controller medication after reporting daily rescue medicine use.

4. Evaluation or surveillance. Any evaluations or testing, whether for the intrinsic disorder or for comorbidities, must be included in the plan as the fourth element. For instance, ordering an A1C test is beneficial in monitoring diabetes, but the evaluation element also reminds physicians to screen for diabetic reti-nopathy or hyperlipidemia.

5. Management. Documentation of treatment or management should always be listed, even if only to write, "Continue carvedilol 12.5 mg bid." Using action verbs such as "resume" or "increase" helps communicate the treatment instructions.

6. Disposition. The final element is disposition. This is likely to include instructions for the patient to return to the clinic after a certain period of time, criteria that should prompt him or her to call the office sooner than scheduled and any actions the patient should perform at home, such as keeping a food diary or blood pressure log.

Following this structure, a note for a confirmed diagnosis might look like this:

- Hypertension: Established, uncontrolled by home blood pressure (BP) log; systolic BP in 150s. Treatment goal: systolic BP in 130s. Complete chemistry pane/ipid/rinalysis in one week. Increase lisinopril now to 20 mg every morning, 60 tabs, five refills. Consult nurse education for dietary approaches to stop hypertension (DASH diet). Return to clinic in one month with BP log.

- Asthma: Established, controlled. Treatment goal: albuterol needed less than three times weekly. Complete annual pulmonary function tests at next visit. Refill mometasone 220 mcg one puff daily. Continue albuterol two puffs four times daily as needed. Return to clinic in three months or sooner per asthma action plan.

Documenting an unconfirmed diagnosis

When documenting an unconfirmed or symptom-based diagnosis, two elements borrowed from the five-step “microskills” model can enhance the note and provide a glimpse into the physician's thoughts.3 It is critically important for the physician to commit to a diagnosis and explain why, among the various differential options, this suspected diagnosis is most applicable to this particular patient. Testing to confirm or rule in the working diagnosis should be listed along with empiric or symptomatic treatment. Less likely diagnoses should be listed next, along with why they are not as probable and how to rule them out. Finally, parameters for reviewing the evaluation and treatment response should be defined. See also “The structured note.”

Following this structure, a note describing symptom-based diagnoses might read as follows:

- Abdominal pain: Suspect biliary dyskinesia due to epigastric location, relation to fatty meals, body habitus and negative right-upper-quadrant ultrasound for gallstones. Confirm with cholescintigraphy (HIDA). Treatment: fatty food avoidance. Doubt pancreatitis given nondrinker and negative ultrasound, but rule out with amylase/lipase. Doubt gastroesophageal reflux disease (GERD) given proton-pump inhibitor use and contrast to usual GERD symptoms. Return to clinic after HIDA scan and consider surgery consult.

- Rash: Suspect allergic photodermatitis given location in sun-exposed areas and onset after use of new sunscreen lotion. Confirm by stopping lotion. Treatment: PABA-free sunscreen. Doubt lupus given no prior history and absence of other complaints. Doubt prescription medications due to no admitted use. Return to clinic if symptoms persist after lotion change.

THE STRUCTURED NOTE

The table below shows the essential components of a detailed assessment and plan.

Confirmed diagnosis	Symptom-based diagnosis	
New or established diagnosis	Suspected diagnosis	SYNCHRONIZE LOCALLY AND GLOBALLY
Stable or uncontrolled	Rationale	
Treatment goal	Evaluation (to confirm)	
Evaluation/surveillance (including related comorbidities)	Management	
Management	Less likely diagnoses	
Disposition	Rationale	
	Evaluation (to rule out)	
	Disposition	

Synchronicity

Finally, synchronicity should be evident in every note both globally and locally, that is, both within and across the major sections. For example, the past medical history should match the medication list. If it doesn't, a reviewing physician may wonder what other aspects of care were sloppy or incomplete. Here's an abbreviated example of poor local synchronization:

- Past medical history: hyperlipidemia, COPD.

- Meds: tiotropium, lisinopril, levothyroxine.

Synchronicity between the subjective/objective (S/O) and the assessment/plan (A/P) sections of the note is also important. For example, if the physician documents three abnormal items in the S/O section, but the A/P only lists two diagnoses, then a mismatch exists between abnormal data collected and assessments made. Not only might this pattern result in underpayment, but it also puts physicians

in indefensible positions if a malpractice case ensues. Most important, it may contribute to patient harm.

Here's an abbreviated example of poor global synchronization:

- Subjective/objective abnormal data: Epigastric burning pain at bedtime, non-scarring hair loss three months postpartum, loss of urine with coughing and laughing.

- Assessment: GERD, telogen effluvium.

Summing it up

Structure and synchronicity are part of disciplined note construction, which is critical to effective communication between physicians. Better documentation may also contribute to clearer medical decision making, which is needed for reimbursement and malpractice defense. Instruction in comprehensive note writing should be promoted in early predoctoral education and continued throughout postgraduate medical training.

About the Author

7. Dr. Crownover is the program director of the Nellis Family Medicine Residency, Nellis Air Force Base, Nevada, and an assistant professor with the Uniformed Services University of the Health Sciences, Bethesda, Md. This article represents the views of the author and does not represent the views of the U.S. Air Force, the Defense Department or the U.S. Government. Author disclosure: no relevant financial affiliations disclosed.

- Send comments to fpmedit@aafp.org.

- 1. Szauter KM, Ainsworth MA, Holden MD, Mercado AC. Do students do what they write and write what they do? The match between the patient encounter and patient note. Acad Med. 2006;81(Suppl 10):S44–S47.

- 2. U.S. Medical Licensing Examination. 2010 Step 2 Clinical Skills: Content Description and General Information. http://download.usmle.org/2010/2010CSinformationmanual.pdf. Accessed May 17, 2011.

- 3. Parrot S, Dobbie A, Chumley H, Tysinger JW. Evidence-based office teaching – the five-step microskills model of clinical teaching. Fam Med. 2006;38(3):164–167.

Attachment 4

Nellis AFB Family Medicine - End of Rotation feedback by resident physicians

Clearly communicates high performance expectations ***(Question 1 of 9 - Mandatory)***

N/A	Poor	Below Average	Average	Above Average	Excellent

Approachable and available ***(Question 2 of 9)***

N/A	Poor	Below Average	Average	Above Average	Excellent

Open to others viewpoints ***(Question 3 of 9)***

N/A	Poor	Below Average	Average	Above Average	Excellent

Teaching Ability ***(Question 4 of 9)***

N/A	Poor	Below Average	Average	Above Average	Excellent

Enthusiasm for teaching ***(Question 5 of 9)***

N/A	Poor	Below Average	Average	Above Average	Excellent

Use of Evidence-Based Information ***(Question 6 of 9 - Mandatory)***

N/A	Poor	Below Average	Average	Above Average	Excellent

Provides timely, descriptive and useful feedback ***(Question 7 of 9 - Mandatory)***

N/A	Poor	Below Average	Average	Above Average	Excellent

Comments ***(Question 8 of 9)***

Please rank this person against other supervising educators ***(Question 9 of 9 - Mandatory)***

N/A	Bottom 76-100%	51-75%	26-50%	11-25%	Top 10%

Review your answers in this evaluation. If you are satisfied with the evaluation, click the SUBMIT button below. Once submitted, evaluations are no longer available for you to make further changes.

Attachment 5

NELLISFAMILY MEDICINE RESIDENCY PROGRAM
POTENTIAL SOLO PROCEDURES UPON GRADUATION

Procedure Name	Supervision Requirements
ACLS & Simulations	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Anoscopy	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Caesarean First Assist	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Caesarean Primary Surgeon	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Circumcision, neonatal	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Colonoscopy	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Colposcopy	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Cryotherapy Skin	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
CXR Interpretation	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
ECG Interpretation	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Endometrial Biopsy	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Fluoroscein Dye Eye	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Home Visit	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
I+D Skin Abscess Drainage	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Injection Joint	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Injection Trigger Point and Tendons	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Nail or FB or wart removal	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Other - ICU patient day of care	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Other - LIST NAME IN NOTES	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)

Pap Smear	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Quality Improvement	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Repair Skin Laceration- Simple or Multilayered	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Skin Biopsy/Excision	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Splinting Sprains and nondisplaced fractures	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Treadmill Standard	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Vaginal Delivery - Continuity Patient	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Vaginal Delivery - Other Than Continuity	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Vasectomy	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)
Wet Prep - KOH and Saline	Level 2- Indirect supervision (supervising physician is on site or available by phone to provide direct supervision)

***** Staff approval is defined as agreement by two credentialed providers that the resident is competent in a given procedure

Attachment 6

DEPARTMENT OF THE AIR FORCE 10 Apr 2011
99th Medical Group (ACC)
Family Medicine Residency
Nellis AFB, NV 89191

JOB DESCRIPTION/PERFORMANCE STANDARDS

1. JOB TITLE: PGY-1 FAMILY MEDICINE RESIDENCY

2. RANK/AFSC: Captain through Colonel 44F1

3. REFERENCES:

AFI 41-117, Medical Service Officer Education
AFI 36-2402, Officer Evaluation System
AFI 44-102, Community Health Management
AFI 44-119, Clinical Performance Improvement

4. QUALIFICATIONS:

4.1. KNOWLEDGE:
Follows Air Force and professional standards particularly those which govern residency training. Demonstrates working knowledge of Air Force, medical group, medical operations, and Joint Commission/AF Health Services Inspection (HSI) regulations and standards. Demonstrates expertise in interpersonal relationships, and the ability to communicate effectively, both orally and in writing.

4.2. EDUCATION: Graduate of accredited U.S. medical school (either LCME or AOA). Will complete Step 3 of the USMLE or COMLEX.

4.3. EXPERIENCE: Membership in professional organizations such as American Academy of Family Physicians and Uniformed Services Academy of Family Physicians is encouraged.

4.4. BENEFITS: Resident learns the specialty of Family Medicine by active participation in patient care and educational activities. Has direct influence on the direction and development of the residency program by his/her input at staff meetings and the residency review annual conference.

4.5. SELECTION: Program will not discriminate with regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status. All applicants will be prescreened by the USAF and only applicants accepted by the USAF for enrollment at the Uniformed Services University (USUHS) or enrollment at an accredited U.S medical school on a Health Professions Scholarship Program (HPSP) will be allowed program entry.

5. JOB SUMMARY

5.1. COMMUNICATION: When giving feedback to medical students, specific language describing observable behaviors is preferred. When communicating up the chain, should work through the senior resident and chief resident first, then the team chief, and then the program director for assistance with any problems.

5.2 COMMITTEE WORK: Will attend weekly Balint meetings, monthly resident council, and monthly resident-staff meetings. Participation in the annual residency review conference is required.

5.3 EDUCATIONAL ACTIVITIES: Prepare small group case studies/didactic lectures and participate in medical readiness exercises. Participate in journal club, morning and noon teaching rounds, monthly theme day block teaching and morbidity & mortality rounds.

5.4 PATIENT DUTIES: Manage panel of 100 patients in both outpatient and inpatient settings. Will begin to longitudinally follow nursing home enrolled patients at local facility. Will perform procedures under the direct, specific supervision of an attending physician, unless noted to have independent privilege status in E*value. Will always be under the general supervision of an attending, which may provide supervision in person or by telephone communication.

5.5 LEADERSHIP: Modeling effective clinical teaching is required. Mentoring medical students in the principles of Family Medicine is expected, especially the concepts of the personal medical home, whole person care, humanizing the medical experience, natural command of uncertain complexity, generative impact on patients' lives, use of information technology, quality improvement, collaborative team-based delivery of care, and evidence-based practice. PGY-1 resident will supervise medical students under the direct guidance and supervision of a Family Medicine Attending.

SUPERVISION RECEIVED:

Direct: Family Medicine Residency Team Chief & Program Director
Indirect: Senior/Chief Residents, Faculty, Director of Medical Education (DME)

SUPERVISION EXERCISED:

Direct: None
Indirect: Medical Students

BRIAN K. CROWNOVER, Col, USAF, MC, FAAFP
Program Director, Family Medicine Residency

DEPARTMENT OF THE AIR FORCE 10 Apr 2011

99th Medical Group (ACC)
Family Medicine Residency
Nellis AFB, NV 89191

JOB DESCRIPTION/PERFORMANCE STANDARDS

1. JOB TITLE: PGY-2 FAMILY MEDICINE RESIDENCY

2. RANK/AFSC: Captain through Colonel 44F1

3. REFERENCES:

AFI 41-117, Medical Service Officer Education
AFI 36-2402, Officer Evaluation System
AFI 44-102, Community Health Management
AFI 44-119, Clinical Performance Improvement

4. QUALIFICATIONS:

4.1. KNOWLEDGE:
Demonstrates basic management and leadership principles in respect to team building. Follows Air Force and professional standards particularly those which govern residency training. Demonstrates working knowledge of Air Force, medical group, medical operations, and Joint Commission/AF Health Services Inspection (HSI) regulations and standards. Demonstrates expertise in interpersonal relationships, and the ability to communicate effectively, both orally and in writing.

4.2. EDUCATION: Graduate of accredited U.S. medical school (either LCME or AOA) and completion of first year of family medicine specialty training.

4.3. EXPERIENCE: Current state licensure must be pursued and completed no later than 31 Dec of the PGY-2 year. Membership in professional organizations such as American Academy of Family Physicians and Uniformed Services Academy of Family Physicians is encouraged.

4.4. BENEFITS: Resident learns the specialty of Family Medicine by active participation in patient care and educational activities. Has direct influence on the direction and development of the residency program by his/her input at staff meetings and the residency review annual conference.

4.5. SELECTION: Program will not discriminate with regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status. All applicants will be prescreened by the USAF and only applicants accepted by the USAF for enrollment at the Uniformed Services University (USUHS) or enrollment at an accredited U.S medical school on a Health Professions Scholarship Program (HPSP) will be allowed program entry.

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5.3 EDUCATIONAL ACTIVITIES: Prepare small group case studies/didactic lectures and participate in medical readiness exercises. Participate in journal club, morning and noon teaching rounds, monthly theme day block teaching and morbidity & mortality rounds. Initiation of scholarly activity project is required.

5.4 PATIENT DUTIES: Manage panel of 250 patients in both outpatient and inpatient settings. Will continue to longitudinally follow nursing home enrolled patients at local facility. Longitudinal emergency medicine and obstetric training will occur intermittently as weekend duty shifts. Will perform procedures under the direct, specific supervision of an attending physician, unless noted to have independent privilege status in E*value. Will always be under the general supervision of an attending, which may provide supervision in person or by telephone communication.

5.5 LEADERSHIP: Modeling effective clinical teaching is required. Mentoring medical students and PGY-1 residents in the principles of Family Medicine is expected, especially the concepts of the personal medical home, whole person care, humanizing the medical experience, natural command of uncertain complexity, generative impact on patients' lives, use of information technology, quality improvement, collaborative team-based delivery of care, and evidence-based practice. PGY-2 resident will supervise PGY-1 residents, under the direct guidance and supervision of a Family Medicine Attending.

SUPERVISION RECEIVED:

Direct: Family Medicine Residency Team Chief & Program Director
Indirect: Chief Resident, Other faculty, Director of Medical Education (DME)

SUPERVISION EXERCISED:

Direct: None
Indirect: PGY-1 Family Medicine Residents, Medical Students

BRIAN K. CROWNOVER, Col, USAF, MC, FAAFP
Program Director, Family Medicine Residency

DEPARTMENT OF THE AIR FORCE 10 Apr 2011

99th Medical Group (ACC)
Family Medicine Residency
Nellis AFB, NV 89191

JOB DESCRIPTION/PERFORMANCE STANDARDS

1. JOB TITLE: PGY-3 FAMILY MEDICINE RESIDENCY

2. RANK/AFSC: Captain through Colonel 44F1

3. REFERENCES:

AFI 41-117, Medical Service Officer Education
AFI 36-2402, Officer Evaluation System
AFI 44-102, Community Health Management
AFI 44-119, Clinical Performance Improvement

4. QUALIFICATIONS:

4.1. KNOWLEDGE:
Demonstrates basic management and leadership principles in respect to team building. Follows Air Force and professional standards particularly those which govern residency training. Demonstrates working knowledge of Air Force, medical group, medical operations, and Joint Commission/AF Health Services Inspection (HSI) regulations and standards. Demonstrates expertise in interpersonal relationships, and the ability to communicate effectively, both orally and in writing.

4.2. EDUCATION: Graduate of accredited U.S. medical school (either LCME or AOA) and completion of first two years of family medicine specialty training. .

4.3. EXPERIENCE: Current state licensure is mandatory. Membership in professional organizations such as American Academy of Family Physicians and Uniformed Services Academy of Family Physicians is encouraged.

4.4. BENEFITS: Resident learns the specialty of Family Medicine by active participation in patient care and educational activities. Has direct influence on the direction and development of the residency program by his/her input at staff meetings and the residency review annual conference.

4.5. SELECTION: Program will not discriminate with regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status. All applicants will be prescreened by the USAF and only applicants accepted by the USAF for enrollment at the Uniformed Services University (USUHS) or enrollment at an accredited U.S medical school on a Health Professions Scholarship Program (HPSP) will be allowed program entry.

5. JOB SUMMARY

5.1. COMMUNICATION: When giving feedback to junior residents and students, specific language describing observable behaviors is preferred. When communicating up the chain, should work through the chief resident first, then the team chief, and then the program director for assistance with any problems.

5.2 COMMITTEE WORK: Will attend weekly Balint meetings, monthly resident council, and monthly resident-staff meetings. Will also attend committee meetings for which the resident's team chief is required to attend; insight and perspective regarding the committee will be shared by the team chief with the resident. Participation in the annual residency review conference is required.

5.3 EDUCATIONAL ACTIVITIES: Prepare small group case studies/didactic lectures and participate in medical readiness exercises. Participate in journal club, morning and noon teaching rounds, monthly theme day block teaching and morbidity & mortality rounds. Will complete ATLS at the Combat Casualty Care Course (C4) if not already done prior. Completion of scholarly activity is required.

5.4 PATIENT DUTIES: Manage panel of 400 patients in both outpatient and inpatient settings. Will continue to longitudinally follow nursing home enrolled patients at local facility. Longitudinal emergency medicine and obstetric training will continue intermittently as weekend duty shifts. Will perform procedures under the direct, specific supervision of an attending physician, unless noted to have independent privilege status in E*value. Will always be under the general supervision of an attending, which may provide supervision in person or by telephone communication.

5.5 LEADERSHIP: Modeling effective clinical teaching is required. Mentoring medical students and junior residents in the principles of Family Medicine is expected, especially the concepts of the personal medical home, whole person care, humanizing the medical experience, natural command of uncertain complexity, generative impact on patients' lives, use of information technology, quality improvement, collaborative team-based delivery of care, and evidence-based practice. PGY-3 resident will supervise junior residents, under the direct guidance and supervision of a Family Medicine Attending.

SUPERVISION RECEIVED:

Direct: Family Medicine Residency Team Chief & Program Director
Indirect: Chief Resident, Other faculty, Director of Medical Education (DME)

SUPERVISION EXERCISED:

Direct: None
Indirect: PGY-1 and PGY-2 Family Medicine Residents, Medical Students

BRIAN K. CROWNOVER, Col, USAF, MC, FAAFP
Program Director, Family Medicine Residency

DEPARTMENT OF THE AIR FORCE 10 Apr 2011

99th Medical Group (ACC)
Family Medicine Residency
Nellis AFB, NV 89191

JOB DESCRIPTION/PERFORMANCE STANDARDS

1. JOB TITLE: CHIEF RESIDENT FAMILY MEDICINE RESIDENCY

2. RANK/AFSC: Captain through Colonel 44F1

3. REFERENCES:

Arbelaez c. The Emergency Medicine Chief Resident Survival Guide. 2006. http://www.emra.org/uploadedFiles/EMRA/Bookstore/ChiefResident.pdf
AFI 41-104, Professional Board and National Certification Examinations
AFI 41-117, Medical Service Officer Education
AFI 36-2406, Officer and Enlisted Evaluation Systems
AFI 44-102, Medical Care Management
AFI 44-119, Medical Quality Operations
MOFMCI 41-18, Procedures and Policies Governing Gain (Recruitment, Eligibility, Selection, Appointment) and Loss (Discipline, Remediation, Dismissal) of Family Medicine Residents
MOFMCI 41-19, Medical Supervision of Residents
UTHSC Chief Resident Articles. http://www.uthscsa.edu/gme/chiefres.asp
Whitman N. The Chief Resident as Manager, 3rd edition. 2007.

4. QUALIFICATIONS:

4.1. KNOWLEDGE:
Understanding of basic management and leadership principles in respect to residency team building. Follows Air Force and professional standards particularly those which govern residency training. Demonstrates working knowledge of Air Force, medical group, medical operations, and Joint Commission/AF Health Services Inspection (HSI) regulations and standards. Demonstrates expertise in interpersonal relationships, and the ability to communicate effectively, both orally and in writing. Applies management and leadership principles in the performance of clinical oversight of Family Medicine.

4.2. EDUCATION: Graduate of accredited medical school and completion of PGY-1 year of family medicine specialty training.

4.3. EXPERIENCE: Current state licensure is mandatory no later than March of PGY-2 year. Membership in professional organizations such as American Academy of Family Physicians and Uniformed Services Academy of Family Physicians is encouraged.

4.4. OTHER: Chief Residents are chosen annually in an election to be held in the spring of the year preceding the term of office. One to two upcoming senior residents are elected to serve as chief residents. Each Family Medicine core faculty and resident have one vote. At the discretion of the program director, residents receiving the most votes will be offered the positions but may elect to decline if unable or unwilling to fulfill the responsibilities. The Program Director maintains the ultimate authority for selecting the most capable residents for this critically important position.

4.5. BENEFITS: Has direct influence on the direction and development of the residency program by his/her input at RDW (residency development workshop) staff meetings and Residency Education Oversight Group (REOG). Has direct influence over the coordination and scheduling of resident call

and clinic duties. Earns the opportunity to develop management skills, teaching skills, role modeling, and troubleshooting skills to positively and profoundly effect morale. Able to apply for the AAFP Chief Resident Leadership Development Conference in spring of PGY-2 year. [http://www.aafp.org/online/en/home/residents/conferences/chiefresident.html] An Air Force decoration may be awarded to Chief Residents for outstanding service.

5. JOB SUMMARY

5.1. COMMUNICATION: A primary responsibility of the chief resident is to be a bridge between the residents and faculty physicians to communicate concerns and educational issues. Helping both groups to see the others' perspective is a constant challenge. When giving feedback, specific language describing observable behaviors is preferred. The chief should strive to make rationale for change transparent to residents to promote group accord. The chief should plan on monthly meetings alone with the program director to allow for communicating more sensitive concerns and promote mentoring opportunities.

5.2 COMMITTEE WORK: The chief will attend weekly Residency Development Workshop (RDW) meetings with the entire faculty. Also will attend the Residency Education Oversight Group (REOG), which reports to the GME Committee (GMEC) overseeing all training programs at the military treatment facility (MTF). The chief will be involved in resident selection and orientation, and is a member of the formal interview team for prospective residents. The chief will provide written assessment of candidates. Additionally, the chief runs monthly Resident Council meetings to make announcements, discuss issues, and gather resident opinion. The chief will summarize current resident concerns at the subsequent monthly Resident/Staff meeting.

5.3 ORGANIZATION: The chief resident will prepare/coordinate the resident yearly rotation schedule; will develop monthly resident call schedules; and coordinate monthly resident clinic schedules in conjunction with the faculty duty scheduler and departments outside of Family Medicine. The chief will coordinate monthly noon lecture schedules. Authority is given to the chief to create and modify the listed schedules. If residents are ill, late or absent from work, the chief has authority to juggle schedules to cover any gaps. The chief will relay to the program director any suspicions regarding serious illnesses, chronic late behavior or unexcused absences. The program director will review the initial yearly rotation schedule to ensure compliance with the latest Residency Review Committee (RRC) guidelines prior to publication. Additionally, the chief will delegate or assist with planning and coordinating of the annual residency review conference, research presentation day, the graduation banquet and ceremony, third year board review sessions, and the summer hail and farewell function.

5.4 LEADERSHIP: Chief residents will function as the middle link in the chain of command between the residents and faculty, serving in a role similar to a unit First Sergeant. They will be an advocate for fellow residents, both as a group and individually, including assisting residents experiencing difficulties academically. As deemed appropriate, the chief resident has the authority to designate duties to other residents, however the chief will ultimately remain accountable for all taskings under his/her control. Conflict resolution by the chief will be needed often, taking both sides of an issue into account. The chief has the authority to resolve most conflicts without involving the program director, however any conflicts that involve a resident being at significant risk for failing a rotation, being a threat to others or self, or any issue that significantly concerns the chief should be communicated to the program director. Modeling effective clinical teaching and encouraging publications/scholarly activity is expected. The chief will enforce policies, procedures, and regulations of the Air Force, medical corps, medical group and residency. The chief resident is expected to exercise authority to counsel and correct deficient behaviors observed among the residents, however the program director will be notified for recurrent deficiencies and maintain formal disciplinary authority.

SUPERVISION RECEIVED:

Direct: Family Medicine Residency Team Chief & Program Director
Indirect: Other residency faculty, Director of Medical Education (DME)

SUPERVISION EXERCISED:

Direct: None
Indirect: First, Second and Third Year Family Medicine Residents

BRIAN K. CROWNOVER, Col, USAF, MC, FAAFP
Program Director, Family Medicine Residency

Attachment 7

Scholarly Activity Requirement

All residents are required to complete a scholarly activity project as a central component of their program. These projects help prepare each resident for a lifetime of self-education and they demonstrate their developing ability to critically evaluate medical research/literature. They also reflect the resident's awareness of the basic principles of study design, performance, analysis, and reporting, as well as the relevance of research to patient care.

Residents have three primary options to select from for their scholarly activity project: (Option 1) Completion of a scholarly project as part of a focused medical Area of Concentration (AOC), (Option 2) Primary research project or (Option 3). Integrative Research consisting of a Family Physician Inquiry Network clinical inquiry (FPIN CI) and clinical case report. Each resident selects their scholarly activity in consultation with their faculty team chief, the residency research director, and other participating resident/hospital staff.

Option One – Area of Concentration (AOC)

Residents can complete a scholarly activity project reflecting their learned knowledge in a specific family medicine-related topic (i.e. AOC). AOC's are focused areas of learning and research where the resident concentrates on one particular area of sub-specialty within Family Medicine (see sample AOC below). They must be submitted in writing to the resident's faculty team chief, approved by the program director, and they must include the following components:

- Competency-based goals and objectives for additional training in the AOC
- How the faculty will determine that the additional training competencies have been achieved
- At least 2 months or 200 hours of training in the area of concentration, above and beyond the RRC requirements
- A scholarly project completed in the AOC (see details below)
- Documentation of attendance at a CME meeting in the AOC (CME must be approved by the program director or faculty team chief)
- Journal club (critical appraisal) presentation of an article in the chosen area
- Quality outcomes must be demonstrated and documented in the AOC with case logs (if relevant to the AOC), patient outcome data and faculty reviews of resident competency in the AOC

AOC topics are selected in collaboration with the resident's team chief. They can be selected from a wide range of potential topics. Some example AOC topics include tropical medicine, women's health, wilderness medicine, pathology, and dermatology. Residents can select other AOC topics not identified here.

The scholarly activity completed by the resident as part of their AOC can be a FPIN/CI, or a clinical case report (see descriptions under Option Three below). The resident may alternatively do a research presentation to an appropriate medical conference such as USAFP (Uniformed Services Academy of Family Physicians) annual conference.

Option Two - Primary Research Project / Performance improvement project

Residents can choose to actively participate in a primary research project. Due to the time limitations of the residency program, residents who select this option are highly encouraged to collaborate with faculty members, or other hospital staff, on existing or new research studies. Their involvement in the project should, at a minimum, include IRB approval, observations of subjects, review/summary of available research literature, formulation of possible hypotheses, creation of the research design, data collection, statistical analysis, development of conclusions. They also present their study findings to the residency and other professional medical forums as available.

Option Three - Integrative Research (FPIN CI and Case report)

This option allows the resident to conduct two integrative research tasks, a clinical case report and a FPIN/CI, in the same or in two distinct areas of practice. Clinical case reports are focused reviews of medically unique patients or conditions. Residents may select a case report from their clinical case load or from one of their rotations. They are co-authored with a staff physician and are submitted for publication by a professional medical journal or for presentation to an appropriate medical conference such as USAFP (Uniformed Services Academy of Family Physicians) annual conference. Case reports are often published by the Journal of the American Board of Family Medicine (www.jabfm.org).

FPIN/CI's are published research answers to practical family medicine questions. They provide the ideal answers to clinical questions: using a structured search, critical appraisal, authoritative recommendations, clinical perspective, and rigorous peer review, Clinical Inquiries deliver best evidence for point of care use. FPIN/CI's are published in Journal of Family Practice or American Family Physician. More information about FPIN/CI's can be found at their website: http://www.fpin.org.

Scholarly Activity Timelines

ALL DUE DATES ARE CONSIDERED NON-NEGOTIABLE

Month/Yr*	**Option 1: AOC (FPIN – option)**	**Option 2: Primary Research**	**Option 3: Integrative Research**
Nov PG 1	Research Workshop	Research Workshop	Research Workshop
Feb PG 1	Select AOC topic/CoAuthor	Select topic/hypothesis	----------
June PG 1	Submit AOC Learning Plan	Submit Lit Search/IRB	Select Case Report (CR)
2b Rotation with research rotation longitudinal time - PG 2	Start - Librarian Lit Search done End 2nd mo – draft FPIN CI to CoAuthor End of 2b rotation – formal submit to FPIN website After 2b rotation – ongoing edits and publication		----------
Nov PG 2	----------		Complete CR Lit search
Jan PG 2	----------	Obtain IRB Approval	Select FPIN CI topic/CoAuthor
Feb PG 2 - Jan PG 3	----------	Ongoing data collection – recommend schedule 2b rotation 2nd half of PG2 yr	----------
Mar PG 2			- Submit CR 1st draft - Librarian CI lit search done
May PG 2			Submit CR revisions
July PG 3		---------	- Submit CR to USAFP poster competition - Submit FPIN/CI draft to CoAuthor
Oct PG 3		---------	- Submit formally to FPIN website
Dec PG 3		---------	-Ongoing CI revisions with FPIN Editor/Reviewer, then publication
Feb PG 3		Complete data analysis (likely need elective during this time)	
Mar PG 3		Compose manuscript	---------
Apr PG 3	Complete 2 electives and CME conference attendance; Validate AOC goal completed	Submit manuscript to faculty adviser	
Jun PG 3	Scholarly presentation	Scholarly presentation	Scholarly presentation

*Note: All dates are no later than dates; residents may complete tasks earlier than month/year listed

SAMPLE AOC

Area of Concentration in Women's Health

I. An area of concentration (AOC) has been developed for Nellis Air Force Base Family Medicine Residents to develop an extended knowledge base in Women's Health. Teaching and scholarly activities will be founded on evidence based medicine to prepare residents for improved care of the female patient.

II. Women's health pertains to the physical, psychological and social well-being of women. This area of study will broaden the resident's knowledge and will take into account (1) the diversity and heterogeneity of women; (2) the variety of concerns that affect their well-being; and (3) a perspective that acknowledges the socio-political context which, in many ways, determines the health of women. Focus will be placed on topics such as contraception and fertility, office gynecology, osteoporosis prevention, abnormal cervical cytology diagnosis and treatment, obstetrical care of the pregnant patient, cancer prevention, menopause, and breast disease.

III. Goals of the women's health concentration are to become competent at caring for low and high risk pregnancies. This includes prenatal care, labor & delivery management, postpartum care and contraceptive management. To become proficient at performing operative vaginal deliveries, focusing on Vacuum Assisted Vaginal Deliveries. This includes understanding indications for such intervention and proficiency at the required skill-set. To be an active educator in the residency program on women's health topics. Demonstration of competency in procedural skills such as colposcopy, LEEP, and endometrial biopsy.

IV. The resident will obtain at least 200 hours of training in the AOC through a combination of classroom education, continued medical education courses, clinical rotations at Nellis Air Force Base, Triservice medical centers such as Ft. Carson Army base, and civilian centers such as Sunrise Hospital.

Specific Educational/Developmental Experiences:

- 2 week rotation in obstetrics at Ft Carson, CO.
- 2 week rotation in complicated outpatient obstetrics at Nellis AFB with Nellis Obstetric staff
- 1 week Planned Parenthood Clinic focusing on contraceptive management, early pregnancy counseling options, surgical and medical therapies for unwanted pregnancies.
- Attending a 5 day continuing medical education conference. annual Obstetric & Gynecology Annual Review course hosted by University of California, Irvine.
- Manage/assist 80 vaginal deliveries.
- Participation in teaching the Advanced Life Support in Obstetrics (ALSO) course with Nellis faculty.
- Attending a 4 day continuing medical education comprehensive colposcopy course sponsored by the American Society for Colposcopy and Cervical Pathology
- Training in colposcopy, LEEP and conization by Nellis Gynecology staff
- Presentation of 2 noon conferences on women's health topics using evidence-based medicine.

V. Residents will complete a scholarly project in the AOC. At a minimum, residents will 1) present a women's health case report or topic at a national CME meeting, or 2) complete original research in women's health or 3) complete a women's health oriented Family Physician Inquiry Network Clinical Inquiry (FPIN/CI). Residents will complete a comprehensive literature search/review and answer an FPIN/CI. This will be presented and evaluated at the local level. It will also be published in Journal of Family Practice or American Family Physician as part of the FPIN process. A copy of this presentation and evaluation will be kept in a portfolio of materials documenting the residents work in the AOC.

a. Original research on "Comparison of Random Urine Protein-Creatinine Ratio to 24-Hour Urine Collection to Diagnose Preeclampsia" awaiting IRB approval. IRB expedited review returned denied. Retrospective study not requiring informed consent being evaluated. Awaiting lab input.
b. Ob case report with Dr. Gould currently underway.

VI. To demonstrate competency the resident will undergo chart review to assure quality of care in the clinical setting. A case log of patients and conditions managed will be required. Upon completion of the AOC, the resident will present his/her portfolio to the Team Chief for verification of all required items. The team chief will present the portfolio to the staff and program director.

Attachment 8

I. IDENTIFICATION DATA *(Read AFI 36-2406 carefully before filling in any item)*

1. NAME *(Last, First, Middle Initial)*	2. SSN	3. GRADE	4. DUTY AFSC
SMITH, MELISSA A.	777-77-7777	Capt	44F1

5. ORGANIZATION, COMMAND, AND LOCATION

99th Medical Operations Squadron (ACC), Nellis AFB, NV

6. PERIOD OF REPORT	7. LENGTH OF COURSE	8. REASON FOR REPORT
FROM: 01 Jul 2009 THRU: 30 Jun 2010	52 WEEK(S)	☒ ANNUAL ☐ FINAL ☐ DIRECTED

9. NAME AND LOCATION OF SCHOOL OR INSTITUTION

Nellis AFB (ACC) Program
99th Medical Operations Squadron (ACC), Nellis AFB, NV

10. NAME OR TITLE OF COURSE

Family Medicine Residency Training Program

II. REPORT DATA *(Complete as applicable for final report)*

1. AFSC/AERO RATING/DEGREE AWARDED

2. ☒ COURSE NOT COMPLETED *(List reason in Item 4 below)*

3. **DISTINGUISHED GRADUATE** ☐ YES *(List criteria in Item 4 below)* ☒ NO DG PROGRAM

4. DG AWARD CRITERIA/COURSE NONCOMPLETION REASON

Has two remaining scheduled years of training

III. COMMENTS *(Mandatory)*

ACADEMIC/TRAINING ACCOMPLISHMENTS

- Capt Smith has successfully completed her internship and the first year of her family medicine residency
- She scored in the 68th percentile on the national in-service examination compared to other first year residents
- Sports Medicine noted that "Capt Smith successfully incoporated her osteopathic skills into her daily practice"
- Ophthamology impressed by her strong work ethic and broad fund of knowledge, awarding 6.9 of 7; top score
- Psychiatry awarded her highest marks, complimented her ability to self teach and her strong empathic style
- Medical students praised Captain Smith as an invaluable role model who has given above and beyond duty
- Neurology commented "strong depth of knowledge--totally engaged in the patient-doctor encounter," rated 5/5
- General Surgery noted "actively sought feedback regarding performance and areas of improvement" rated 4/5
- Faculty on Family Med team felt she was "eager to learn/genuine/teachable" with "legible organized notes"

PROFESSIONAL QUALITIES *(Bearing, appearance, conduct, fitness)*

- Capt Smith meets the Air Force standards for bearing, appearance, conduct, professionalism and fitness
- Researcher; developed initial steps for pursuit of Area of Concentration in challenging field/amputee care
- Talented instructor; demonstrated abilities during morning report, lecture, journal club, or clinical rounds
- Growing leadership; sought/constructed strategy for leadership development; focused on service to others
- Compassionate physician; frequently sacrificed personal time to assist in care of patients/listened to concerns

OTHER COMMENTS *(Optional)*

Capt Smith has demonstrated tremendous capabilities in patient care and as a medical officer throughout her first year of family medicine training. She brings a wealth of compassion to each patient encounter and every interaction with colleagues. Her knowlege base is well established and continues to grow daily due to her diligence and inteligence. With her wealth of experience and positive outlook, she is an asset to our training program and to the Air Force. She has earned promotion to 2nd year status; ready to assume the supervisor role!

IV. EVALUATOR

NAME, GRADE, BR OF SVC, ORGN, COMD, LOCATION	DUTY TITLE	DATE
BRIAN CROWNOVER, Lt Col, USAF, MC 99th Medical Operations Squadron (ACC) Nellis AFB, NV	Family Medicine Residency Director	30 Jun 2010
	SSN: 7777	SIGNATURE

AF FORM 475, 20000601 *(IMT-V3)* PREVIOUS EDITION IS OBSOLETE **EDUCATION/TRAINING REPORT**

FOR OFFICIAL USE ONLY *(when filled in)*

ACADEMIC/CLINICAL EVALUATION REPORT

Date of Report: 20100630

AUTHORITY: Title 10, U.S.C. Chapter 55, Sections 1094 and 1102.
PRINCIPAL PURPOSE: To evaluate the performance of providers while in an academic setting.
ROUTINE USE: Information on this form may be released to government boards or agencies, or to professional societies or organizations, if needed to license or monitor professional standards of health care providers. It also may be released to civilian medical institutions or organizations where the provider is applying for staff privileges during or after separating from the Air Force.
DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in the limitation of progress in the academic program or limitation of clinical privileges.

NAME (Last)	(First)	(MI)	GRADE	SSN
SMITH	MELISSA	A	CAPT	777-77-7777

MEDICAL FACILITY	CLINICAL SERVICE ROTATION	SERVICE AS
99th Medical Operations Squadron (ACC)	Family Medicine	☐ STUDENT ☐ INTERN ☒ RESIDENT ☐ FELLOW

ATTENDING STAFF PHYSICIAN (Last Name)	(First Name)	(MI)	PERIOD OF SERVICE COVERED BY REPORT
CRAWFORD	PAUL	F	FROM: 20090701 TO: 20100630

INSTRUCTIONS: In evaluating the ratee's performance, use as your standard the level of knowledge, skills, and attitude expected from the clearly satisfactory level at the appropriate stage of training. Specific comments, recommendations for improvement, and future expectations are required for any component that the rater identifies requiring further attention or scored as a 4 or less. In the comments section, provide specific examples, including reports of critical incidents and/or outstanding performance. Global adjectives or remarks such as, "good resident," do not provide meaningful feedback to the ratee.

I. CLINICAL PERFORMANCE

SECTION A - GENERAL MEDICAL KNOWLEDGE

☐ INSUFFICIENT CONTACT TO EVALUATE

Limited Knowledge Of Basic And Clinical Sciences; Minimal Interest In Learning; Does Not Understand Complex Relations, Mechanisms Of Disease	UNSATISFACTORY	SATISFACTORY	SUPERIOR	Exceptional Knowledge Of Basic And Clinical Sciences; Highly Resourceful Development Of Knowledge; Comprehensive Understanding Of Complex Relationships, Mechanisms Of Disease
	☐1 ☐2 ☐3	☐4 ☐5 ☐6	☒7 ☐8 ☐9	
	☐ PERFORMANCE REQUIRES ATTENTION (When checked, specifics are required in comments block.)			

(Comments)

SECTION B - PATIENT ASSESSMENT

☐ INSUFFICIENT CONTACT TO EVALUATE

Incomplete, Inaccurate Medical Interviews, Physical Examinations, And Review Of Other Data; Fails To Consider Patient Preferences When Making Medical Decisions.	UNSATISFACTORY	SATISFACTORY	SUPERIOR	Superb, Accurate, Comprehensive, Medical Interviews, Physical Examinations, And Review Of Other Data; Appropriate Consideration Of Patient Preferences.
	☐1 ☐2 ☐3	☐4 ☐5 ☐6	☒7 ☐8 ☐9	
	☐ PERFORMANCE REQUIRES ATTENTION (When checked, specifics are required in comments block.)			

(Comments)

SECTION C - DIAGNOSTIC ACUMEN

☐ INSUFFICIENT CONTACT TO EVALUATE

Fails To Analyze Available Clinical Data; Uses Poor Judgment In Selection Of Diagnostic Procedures.	UNSATISFACTORY	SATISFACTORY	SUPERIOR	Consistently Makes Appropriate Diagnosis; Uses Sound Judgment In The Selection Of Diagnostic Procedures.
	☐1 ☐2 ☐3	☐4 ☐5 ☒6	☐7 ☐8 ☐9	
	☐ PERFORMANCE REQUIRES ATTENTION (When checked, specifics are required in comments block.)			

(Comments)

SECTION D - PLANNING, IMPLEMENTING AND EVALUATING THERAPY

☐ INSUFFICIENT CONTACT TO EVALUATE

Contributes Little To Initial Patient Evaluation And Provides Little Input Into Appropriate Therapy; Poor Knowledge And Ability In Procedural Techniques.	UNSATISFACTORY	SATISFACTORY	SUPERIOR	Demonstrates Excellent Management And Understanding Of Appropriate Therapy; Implements Correct Therapeutic Techniques With Minimal To No Supervision.
	☐1 ☐2 ☐3	☐4 ☐5 ☐6	☒7 ☐8 ☐9	
	☐ PERFORMANCE REQUIRES ATTENTION (When checked, specifics are required in comments block.)			

(Comments)

SECTION E - TECHNICAL SKILLS

☐ INSUFFICIENT CONTACT TO EVALUATE

Lacks Appropriate Psychomotor Skills To Accomplish Simple Tasks	UNSATISFACTORY	SATISFACTORY	SUPERIOR	Excellent Technical Skills With Economy Of Motion; Appropriate Selection Of Instruments And Techniques
	☐1 ☐2 ☐3	☐4 ☐5 ☐6	☒7 ☐8 ☐9	
	☐ PERFORMANCE REQUIRES ATTENTION (When checked, specifics are required in comments block.)			

(Comments)

II. INTERPERSONAL & COMMUNICATIONS SKILLS

SECTION F - ESTABLISHING EFFECTIVE PHYSICIAN-PATIENT RELATIONSHIP

☐ INSUFFICIENT CONTACT TO EVALUATE

Unable To Establish Even Minimal Rapport With Patients; Tactless And Inflammatory Interchanges; Fails To Demonstrate Listening And Nonverbal Skills	UNSATISFACTORY	SATISFACTORY	SUPERIOR	Exceptional Rapport With Patients And Families; Instills Confidence In Patients; Exerts A Positive Influence; Demonstrates Excellent Relationship Building Through Listening, Narrative, And Nonverbal Skills
	☐1 ☐2 ☐3	☐4 ☐5 ☒6	☐7 ☐8 ☐9	
	☐ PERFORMANCE REQUIRES ATTENTION (When checked, specifics are required in comments block.)			

(Comments)

SECTION G - PROFESSIONAL INTERACTION AND COLLABORATION

☐ INSUFFICIENT CONTACT TO EVALUATE

Integrates Poorly With Professional Staff; Not Viewed As A Team Player; Often The Source Of Complaints From Others; Lacks Respect, Integrity, And Honesty	UNSATISFACTORY	SATISFACTORY	SUPERIOR	Establishes Excellent Working Rapport With Hospital Staff; A Real Team Player; Excellent Interpersonal Skills; Demonstrates Respect, Integrity, And Honesty
	☐1 ☐2 ☐3	☐4 ☐5 ☒6	☐7 ☐8 ☐9	
	☐ PERFORMANCE REQUIRES ATTENTION (When checked, specifics are required in comments block.)			

(Comments)

AF IMT 494, 20040311 (V1)

III. PROFESSIONALISM

SECTION H - ATTITUDE AND APPEARANCE — ☐ INSUFFICIENT CONTACT TO EVALUATE

	UNSATISFACTORY	SATISFACTORY	SUPERIOR	
Immature Behavior, Often Inappropriate; Poorly Groomed; Unprofessional In Actions And Appearance; Lacks Integrity	☐ 1 ☐ 2 ☐ 3	☐ 4 ☐ 5 ☐ 6	☐ 7 ☒ 8 ☐ 9	Maturity, Behavior, Integrity, And Grooming Are Consistent With The Highest Ideals Of The Profession

PERFORMANCE REQUIRES ATTENTION ☐ *(When checked, specifics are required in comments block.)*

(Comments)

SECTION I - LEADERSHIP AND RESPONSIBILITY — ☐ INSUFFICIENT CONTACT TO EVALUATE

	UNSATISFACTORY	SATISFACTORY	SUPERIOR	
Totally Passive; No Initiative; Refuses To Accept Responsibility	☐ 1 ☐ 2 ☐ 3	☐ 4 ☐ 5 ☐ 6	☒ 7 ☐ 8 ☐ 9	Aggressively Assumes Medical Responsibilities; Devotes Time And Energy Selflessly To All Duties; Is Respected By His Peers

PERFORMANCE REQUIRES ATTENTION ☐ *(When checked, specifics are required in comments block.)*

(Comments)

IV. SYSTEM BASED PRACTICE

SECTION J - FULFILLING ADMINISTRATIVE OBLIGATIONS — ☐ INSUFFICIENT CONTACT TO EVALUATE

	UNSATISFACTORY	SATISFACTORY	SUPERIOR	
Shows Little Interest or Understanding of Hospital or Departmental Policies and Instruction; Resists Efforts to Improve Systems of Care; Fails to Use Systematic Approaches to Reduce Error and Improve Patient Care	☐ 1 ☐ 2 ☐ 3	☐ 4 ☐ 5 ☐ 6	☐ 7 ☒ 8 ☐ 9	Comprehensive And In-Depth Understanding Of Policies And Instructions; Effectively Uses Them To Enhance Practice Capabilities And Economy Of System; Uses Systematic Approaches To Reduce Errors And Improve Patient Care

PERFORMANCE REQUIRES ATTENTION ☐ *(When checked, specifics are required in comments block.)*

(Comments)

SECTION K - KEEPING MEDICAL RECORDS — ☐ INSUFFICIENT CONTACT TO EVALUATE

	UNSATISFACTORY	SATISFACTORY	SUPERIOR	
Infrequent And/Or Inaccurate Notes Of Patient Progress	☐ 1 ☐ 2 ☐ 3	☐ 4 ☐ 5 ☐ 6	☒ 7 ☐ 8 ☐ 9	At Appropriate Intervals Routinely Annotates Clear, Comprehensive Progress Notes; Intelligently Interprets And Documents All Aspects Of Patient Care

PERFORMANCE REQUIRES ATTENTION ☐ *(When checked, specifics are required in comments block.)*

(Comments)

SECTION L - PARTICIPATES IN CONTINUING MEDICAL EDUCATION — ☐ INSUFFICIENT CONTACT TO EVALUATE

	UNSATISFACTORY	SATISFACTORY	SUPERIOR	
Poor Attendance/Poor Participation In Conferences And Rounds; Shows Little Evidence Of Outside Reading And Research	☐ 1 ☐ 2 ☐ 3	☐ 4 ☐ 5 ☐ 6	☐ 7 ☐ 8 ☒ 9	Outstanding Attendance And Participation In Academic Conferences And Rounds; Shows Evidence Of Aggressive Reading; Often Accurately Refers To The Literature; Shows Interest And Participates In Ongoing Research

PERFORMANCE REQUIRES ATTENTION ☐ *(When checked, specifics are required in comments block.)*

(Comments)

One of the best read residents I have worked with!

SECTION M - SELF-EVALUATION AND USE OF CONSULTANTS — ☐ INSUFFICIENT CONTACT TO EVALUATE

	UNSATISFACTORY	SATISFACTORY	SUPERIOR	
Lacks Insight Into Personal Inadequacies; Fails To Seek Advice Or Assistance When Needed	☐ 1 ☐ 2 ☐ 3	☐ 4 ☐ 5 ☐ 6	☒ 7 ☐ 8 ☐ 9	Outstanding Insight Into Personal Limitations; Consistently Seeks Advice Of Consultants As Appropriate; Sound Judgment Into Personal Initiatives

PERFORMANCE REQUIRES ATTENTION ☐ *(When checked, specifics are required in comments block.)*

(Comments)

SECTION N - TEACHING — ☐ INSUFFICIENT CONTACT TO EVALUATE

	UNSATISFACTORY	SATISFACTORY	SUPERIOR	
Unable To Effectively Teach Others	☐ 1 ☐ 2 ☐ 3	☐ 4 ☐ 5 ☐ 6	☒ 7 ☐ 8 ☐ 9	Recognized As An Excellent Teacher By Supervisors And Students; Clearly, Concisely, And Patiently Teaches Technical Skills; Serves As A Role Model

PERFORMANCE REQUIRES ATTENTION ☐ *(When checked, specifics are required in comments block.)*

(Comments)

V. OVERALL CLINICAL COMPETENCE DURING ROTATION

SECTION O - RATER EVALUATION

	UNSATISFACTORY	SATISFACTORY	SUPERIOR
ATTENDING PHYSICIAN	☐ 1 ☐ 2 ☐ 3	☐ 4 ☐ 5 ☐ 6	☒ 7 ☐ 8 ☐ 9

(Comments)

CAREER POTENTIAL *(Continue in the additional comments block if necessary)*

RECOMMENDED FOR FURTHER TRAINING ☒ YES ☐ NO SPECIALTY: Chosen

ADDITIONAL COMMENTS

Capt Smith has successfully completed her first year of the Family Medicine Residency. She received rotation evaluations that on average correspond to a 7.5 on a 1-9 scale. She scored in the 88th percentile of all family medicine residents nationwide taking the annual in-training examination. She has an exceptional knowledge base, self motivated learning style, and is highly organized. Her managerial skills, analytic abilities, and solution-oriented insight have and will continue to serve her well during her Air Force career.

SIGNATURES	DATE
ATTENDING STAFF PHYSICIAN	
PROGRAM DIRECTOR	
TRAINEE	

AF IMT 494, 20040311 ***(V1)***

CLINICAL PRIVILEGES – FAMILY PRACTICE AND PRIMARY CARE PHYSICIANS

AUTHORITY: Title 10, U.S.C. Chapter 55, Sections 1094 and 1102.
PRINCIPAL PURPOSE: To define the scope and limits of practice for individual providers. Privileges are based on evaluation of the individual's credentials and performance.
ROUTINE USE: Information on this form may be released to government boards or agencies, or to professional societies or organizations, if needed to license or monitor professional standards of health care providers. It may also be released to civilian medical institutions or organizations where the provider is applying for staff privileges during or after separating from the Air Force.
DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in the limitation or termination of clinical privileges.

INSTRUCTIONS

APPLICANT: In Part I, enter Code 1, 2, or 4 in each REQUESTED block for every privilege listed. This is to reflect current capability and should not consider any known facility limitations. Sign and date the form. Forward the form to your Clinical Supervisor. *(Make all entries in ink.)*

CLINICAL SUPERVISOR: In Part I, using the facility master privileges list, enter Code 1, 2, 3, or 4 in each VERIFIED block in answer to each requested privilege. In Part II, check appropriate block either to recommend approval, to recommend approval with modification, or to recommend disapproval. Sign and date the form. Forward the form to the Credentials Function. *(Make all entries in ink.)*

CODES:
1. **Fully competent within defined scope of practice.** ***(Clinical oversight of some allied health providers is required as defined in AFI 44-119.)***
2. **Supervision required.** ***(Unlicensed/uncertified or lacks current relevant clinical experience.)***
3. **Not approved due to lack of facility support.** ***(Reference facility master privileges list.)***
4. **Not requested/not approved due to lack of expertise or proficiency, or due to physical disability or limitation.**

CHANGES: Any change to a verified/approved privileges list must be mad e in accordance with AFI 44-119.

NAME OF APPLICANT *(Last, First, Middle Initial)*	NAME OF MEDICAL FACILITY
Smith, Melissa A.	99TH MEDICAL GROUP

I. LIST OF CLINICAL PRIVILEGES – FAMILY PRACTICE AND PRIMARY CARE PHYSICIANS

Requested	Verified	
		A. CORE PRIVILEGES
		1. OUTPATIENT
		a. Pediatrics
		(1) Well-child care
		(2) Office pediatric problems
		b. Obstetrics
		(1) Uncomplicated prenatal care
		(2) Threatened abortion
		(3) Complicated *(high risk)* prenatal outpatients with appropriate consultation from staff obstetrician
		c. Gynecology
		(1) Office gynecologic care
		d. Internal Medicine and Medicine Subspecialties
		(1) Office adult internal medicine
		(2) Office neurologic problems
		(3) Office dermatologic problems not including psoriasis, actinic keratoses, or malignant skin tumors
		(4) Uncomplicated psoriasis and actinic keratosis
		e. Surgery and Surgical Subspecialties
		(1) Office orthopedic problems
		(2) Office otorhinolaryngologic problems
		(3) Office ophthalmologic problems not including iritis and glaucoma
		f. Behavioral Health
1		**(1) Office behavioral problems, including crisis intervention and short-term individual, family, and marital counseling**
		2. INPATIENT
		a. Pediatrics
		(1) Uncomplicated inpatient pediatric problems
		(2) Routine care of the newborn
		(3) Complicated pediatric problems using appropriate consultation with staff pedicatricians when clinically indicated

Requested	Verified	
		(3) Complicated pediatric problems (continued)
		(a) Serious infections *(meningitis, pneumonia, septic arthritis, etc.)*
		(b) Fluid and electrolyte problems
		(c) Neonatal sepsis
		(d) Mild neonatal respiratory distress
		(e) Status asthmaticus
		b. Obstetrics
		(1) Routine uncomplicated labor
		(2) Complicated obstetrical problems using appropriate consultation with staff obstetricians when clinically indicated
		(a) Preeclampsia and eclampsia
		(b) Chronic hypertension
		(c) Premature labor
		(d) Premature rupture of membranes
		(e) Prolapsed umbilical cord
		(f) Fetal distress syndrome
		(g) Arrest of labor
		(h) Postpartum hemorrhage
		(i) Postpartum endometritis
		(j) Third trimester bleeding
		(k) Hyperemesis gravidarum
		(l) Pyelonephritis and other UTIs
		(m) Amnionitis
		(n) Intrauterine fetal death
		c. Gynecology
		(1) Complicated inpatient gynecologic problems using appropriate consultation with staff gynecologists when clinically indicated
		(a) Acute pelvic inflammatory disease
		(b) Incomplete abortion
		d. Internal Medicine and Medicine Subspecialties
		(1) Uncomplicated adult internal medicine problems, not including ICU or CCU care
		(2) Uncomplicated inpatient neurologic problems

I.		LIST OF CLINICAL PRIVILEGES – FAMILY PRACTICE AND PRIMARY CARE PHYSICIANS *(Continued)*			
Requested	Verified		Requested	Verified	
		d. Internal Medicine and Medicine Subspecialties (continued)			b. Dermatology (continued)
					(2) Simple laceration repair
		(3) Complicated adult internal medicine problems using appropriate consultation when clinically indicated:			(3) Simple abscess incision and drainage
					(4) Excision of skin and subcutaneous lesions felt to be non-malignant
		(a) Acute myocardial infarction not accompanied by serious cardiac decompensation or serious arrhythmia			(5) Excision of skin tumors felt to be malignant *(basal cell carcinoma, squamous cell carcinoma)*
		(b) Congestive heart failure			c. Internal Medicine
		(c) Diabetic ketoacidosis			(1) Lumbar puncture
		(d) Serious fluid and electrolyte abnormalities			(2) Thoracentesis
		(e) Status asthmaticus			(3) Sigmoidoscopy with biopsy
		(f) Acute gastrointestinal bleeding			(4) Bone marrow aspiration and biopsy
		(g) Chronic obstructive pulmonary disease with respiratory decompensation not requiring ventilator support			(5) Stress electrocardiography *(treadmill)*
					d. Pediatrics
					(1) Suprapubic bladder aspiration
		(h) Serious infections (meningitis, pneumonia, sepsis, etc.)			(2) Neonatal circumcision
					(3) Umbilical artery catheterization
		(i) Undiagnosed anemias			(4) Umbilical vein catheterization
		(j) Uremia			(5) Intubation
		(k) Severe drug overdose			e. Surgical and Surgical Subspecialties
		(l) Alcohol withdrawal syndromes			(1) Bladder catheterization
		(m) Bleeding and coagulation disorders			(2) Removal of ocular foreign body
		(n) Blood dyscrasias			(3) Removal of nasal foreign body
		(o) Hypertensive crises			(4) Vasectomy
		(4) Complicated adult neurologic problems with appropriate consultation with staff neurologists when clinically indicated			(5) Arthrocentesis
					(6) Closed reduction of simple fractures and dislocations
		(a) Status epilepticus			f. Obstetrics
		(b) Cerebrovascular accident (CVA)			(1) Routine vaginal delivery without the use of forceps or vacuum
		(c) Coma of undetermined etiology			
		e. Surgery and Surgical Subspecialties			(2) Manual extraction of the placenta
		(1) Uncomplicated musculoskeletal problems *(muscle spasms, strains, back pain, etc.)*			(3) Outlet vacuum delivery
					(4) Induction of labor
		(2) Uncomplicated urologic problems *(epidydimitis, prostatitis, pyelonephritis, bleeding and other complications of vasectomy)*			(5) Limited obstetric ultrasound *(fetal position, fetal cardiac activity, etc.)*
					g. Gynecology
					(1) Perform Papanicolaou (Pap) smears
		(3) Management of spontaneous pneumothorax without serious respiratory compromise with appropriate consultation with a general or throracic surgeon when clinically indicated			(2) Endometrial biopsy
					(3) Cervical biopsy
					(4) Intrauterine device (IUD) insertion/removal
		(4) First assist at major surgical procedures			B. SUPPLEMENTAL PRIVILEGES
		3. PROCEDURES			1. OUTPATIENT
		a. Emergency			a. Other *(Specify)*
		(1) Basic life support (BLS)			
		(2) Advanced cardiac life support (ACLS)			2. INPATIENT
		(3) Crycothyroidotomy			a. Other *(Specify)* Elective cardioversion
		(4) Tube thoracostomy *(chest tube)*			
		(5) Endotracheal intubation			3. PROCEDURES
		(6) Central venipuncture and catheterization			a. Emergency
		(7) Insertion of arterial line			(1) Venous cutdown
		(8) Cardioversion of life threatening arrhythmia			(2) Tracheostomy
		b. Dermatology			(3) Other *(Specify)*
1		(1) Punch biopsy			

I. LIST OF CLINICAL PRIVILEGES – FAMILY PRACTICE AND PRIMARY CARE PHYSICIANS *(Continued)*

Requested	Verified		Requested	Verified	
		3. PROCEDURES (continued)			3. PROCEDURES (continued)
		b. Dermatology			e. Obstetrics
		(1) Repair of skin laceration involving more than one layer of closure			(1) Repair of cervical, vaginal, and fourth degree perineal lacerations following delivery
		(2) Other *(Specify)* CRYOTHERAPY FOR SUPERFICIAL SKIN LESIONS			(2) Low forceps delivery
		c. Internal Medicine			(3) Other *(Specify)* C-SECTION
		(1) Paracentesis			
		(2) Colonoscopy			f. Gynecology
		(3) Other *(Specify)* EGD			(1) Colposcopy
					(2) Vaginal diaphragm fitting
		d. Surgery and Surgical Subspecialties			(3) Other *(Specify)* Implanon contraception insertion/remova
		(1) Nasolaryngoscopy			
		(2) Management of fingertip amputation			C. OTHER *(Specify)*
		(3) Posterior nasal pack			1. Full biophysical profile
		(4) Breast mass aspiration			2. Amniotomy
		(5) Other *(Specify)* Casting/Splinting of uncomplicated ortho problems			3. Repair 3rd degree peritineal/cerv/vag laceration
					4. Fetal scalp electrode and IUPC placement

SIGNATURE OF APPLICANT	DATE

II. CLINICAL SUPERVISOR'S RECOMMENDATION

☐ RECOMMEND APPROVAL ☐ RECOMMEND APPROVAL WITH MODIFICATION *(Specify below)* ☐ RECOMMEND DISAPPROVAL *(Specify below)*

REQUESTED	VERIFIED	PRIVILEGE
_____	_____	Conscious Sedation
_____	_____	FNA-thyroid, FNA limph node
_____	_____	Management of hyphema and iritis with appropriate consultation if needed
_____	_____	Management of ICU/CCU patients, with appropriate consultation
_____	_____	Management of glaucoma with appropriate consultation
_____	_____	Ventilator management with appropriate consultation
_____	_____	Pediatric/Neonatal lumbar puncture
_____	_____	Toenail removal / nailbed ablation
_____	_____	Soft tissue / Trigger point injections
_____	_____	Sclerotherapy
_____	_____	Tympanometry
_____	_____	Hemorrhoidal banding
_____	_____	Anoscopy
_____	_____	EKG interpretation
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

Supervision is required on all items approved with a Code 2; they cannot be performed independently.

SIGNATURE OF CLINCAL SUPERVISOR (Include typed, printed, or stamped signature block)	DATE

Attachment 9

Nellis Air Force Base - Family Medicine 360° Eval Form

Subject:	
Evaluator:	
Site:	
Period:	
Dates of Activity:	
Activity:	
Evaluation Type:	360 °

I know this person well *(Question 1 of 14 - Mandatory)*

Not Observed	Disagree	Neutral	Agree
0	1	2	3

Knowledge & decision-making are appropriate for level of training *(Question 2 of 14 - Mandatory)*

Not Observed	Disagree	Neutral	Agree
0	1	2	3

I recommend this doctor to friends and family *(Question 3 of 14 - Mandatory)*

Not Observed	Disagree	Neutral	Agree
0	1	2	3

Communicates clearly: verbally (handoffs) and written (chart documentation) *(Question 4 of 14 - Mandatory)*

Not Observed	Disagree	Neutral	Agree
0	1	2	3

Seeks to understand others' views *(Question 5 of 14 - Mandatory)*

Not Observed	Disagree	Neutral	Agree
0	1	2	3

Courteous and considerate of others *(Question 6 of 14 - Mandatory)*

Not Observed	Disagree	Neutral	Agree
0	1	2	3

Shows patient ownership & sense of duty *(Question 7 of 14 - Mandatory)*

Not Observed	Disagree	Neutral	Agree
0	1	2	3

Dress and appearance appropriate for situation *(Question 8 of 14 - Mandatory)*

Not Observed	Disagree	Neutral	Agree
0	1	2	3

Takes initiative and provides leadership *(Question 9 of 14 - Mandatory)*

Not Observed	Disagree	Neutral	Agree
0	1	2	3

Timeliness in completing charts & paperwork *(Question 10 of 14 - Mandatory)*

Not Observed	Disagree	Neutral	Agree
0	1	2	3

Asks for feedback & willing to act on it *(Question 11 of 14 - Mandatory)*

Not Observed	Disagree	Neutral	Agree
0	1	2	3

Truly helps others learn 1:1 or in group setting *(Question 12 of 14 - Mandatory)*

Not Observed	Disagree	Neutral	Agree
0	1	2	3

Descriptive Words (Please select 2-3 words that best describe this resident) *(Question 13 of 14 - Mandatory)*

	Abrasive		Insecure
	Apathetic		Intelligent
	Argumentative		Irresponsible
	Arrogant		Logical
	Attentive		Mature
	Capable		Organized
	Careless		Obnoxious
	Clear-thinking		Poised
	Cocky		Resourceful
	Confident		Rigid
	Conscientious		Rude
	Considerate		Sarcastic
	Cooperative		Selfish
	Dangerous		Sincere
	Dependable		Tactful
	Efficient		Tactless
	Friendly		Undependable
	Honest		Understanding
	Immature		Unfriendly
	Impatient		Unintelligent
	Inconsiderate		Unorganized
	Indifferent		Unscrupulous
	Inept		Wise

What would you like to see this doctor do more frequently? *(Question 14 of 14)*

Attachment 10

Nellis Air Force Base- Family Medicine Resident End of Month Summative Eval

Patient Care

Obtains a complete medical history *(Question 1 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed to grasp competency; Fail evaluation	Limited demonstration of competency; Pass with reservations; 4th yr Medical student level	Fair demonstration of competency; Pass; Junior resident level performance	Strong demonstration of competency; Senior resident level performance	Mastery of competency; performs at faculty level
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5

Conducts a tailored, thorough physical examination *(Question 2 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed to grasp competency; Fail evaluation	Limited demonstration of competency; Pass with reservations; 4th yr Medical student level	Fair demonstration of competency; Pass; Junior resident level performance	Strong demonstration of competency; Senior resident level performance	Mastery of competency; performs at faculty level
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5

Documents appropriate clinical reasoning and management plans *(Question 3 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed to grasp competency; Fail evaluation	Limited demonstration of competency; Pass with reservations; 4th yr Medical student level	Fair demonstration of competency; Pass; Junior resident level performance	Strong demonstration of competency; Senior resident level performance	Mastery of competency; performs at faculty level
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5

Forms therapeutic relationship engaging patient's needs *(Question 4 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed to grasp competency; Fail evaluation	Limited demonstration of competency; Pass with reservations; 4th yr Medical student level	Fair demonstration of competency; Pass; Junior resident level performance	Strong demonstration of competency; Senior resident level performance	Mastery of competency; performs at faculty level
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5

Medical Knowledge

Demonstrates knowledge of rotation objectives *(Question 5 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed	Limited demonstration of	Fair demonstration of	Strong demonstration of	Mastery of competency; performs at

	to grasp competency; Fail evaluation	competency; Pass with reservations; 4th yr Medical student level	competency; Pass; Junior resident level performance	competency; Senior resident level performance	faculty level
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5

Practice-Based Learning and Improvement
Understands own limits and seeks help from faculty/peers *(Question 6 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed to grasp competency; Fail evaluation	Limited demonstration of competency; Pass with reservations; 4th yr Medical student level	Fair demonstration of competency; Pass; Junior resident level performance	Strong demonstration of competency; Senior resident level performance	Mastery of competency; performs at faculty level
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5

Critically evaluates and assimilates evidence-based literature *(Question 7 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed to grasp competency; Fail evaluation	Limited demonstration of competency; Pass with reservations; 4th yr Medical student level	Fair demonstration of competency; Pass; Junior resident level performance	Strong demonstration of competency; Senior resident level performance	Mastery of competency; performs at faculty level
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5

Able to educate peers, ancillary providers, and patients *(Question 8 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed to grasp competency; Fail evaluation	Limited demonstration of competency; Pass with reservations; 4th yr Medical student level	Fair demonstration of competency; Pass; Junior resident level performance	Strong demonstration of competency; Senior resident level performance	Mastery of competency; performs at faculty level
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5

Interpersonal and Communication Skills
Effectively communicates with all members the healthcare team *(Question 9 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed to grasp competency; Fail evaluation	Limited demonstration of competency; Pass with reservations; 4th yr Medical student level	Fair demonstration of competency; Pass; Junior resident level performance	Strong demonstration of competency; Senior resident level performance	Mastery of competency; performs at faculty level
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5

Readily receives teaching and feedback *(Question 10 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed to grasp competency; Fail evaluation	Limited demonstration of competency; Pass with reservations; 4th yr Medical student level	Fair demonstration of competency; Pass; Junior resident level performance	Strong demonstration of competency; Senior resident level performance	Mastery of competency; performs at faculty level
0	1	2	3	4	5

Professionalism
Maintains confidentiality *(Question 11 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed to grasp competency; Fail evaluation	Limited demonstration of competency; Pass with reservations; 4th yr Medical student level	Fair demonstration of competency; Pass; Junior resident level performance	Strong demonstration of competency; Senior resident level performance	Mastery of competency; performs at faculty level
0	1	2	3	4	5

Completes tasks on time; punctual/available for assigned duties *(Question 12 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed to grasp competency; Fail evaluation	Limited demonstration of competency; Pass with reservations; 4th yr Medical student level	Fair demonstration of competency; Pass; Junior resident level performance	Strong demonstration of competency; Senior resident level performance	Mastery of competency; performs at faculty level
0	1	2	3	4	5

Honestly acknowledges mistakes and works to correct them *(Question 13 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed to grasp competency; Fail evaluation	Limited demonstration of competency; Pass with reservations; 4th yr Medical student level	Fair demonstration of competency; Pass; Junior resident level performance	Strong demonstration of competency; Senior resident level performance	Mastery of competency; performs at faculty level
0	1	2	3	4	5

Systems-Based Practice
Understands how to obtain services through consultants/planners *(Question 14 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed to grasp competency; Fail evaluation	Limited demonstration of competency; Pass with reservations; 4th yr Medical student level	Fair demonstration of competency; Pass; Junior resident level performance	Strong demonstration of competency; Senior resident level performance	Mastery of competency; performs at faculty level

0	1	2	3	4	5

Understands coding documentation criteria for levels of care *(Question 15 of 18 - Mandatory)*

Insufficient Observation	Unacceptable performance; clearly failed to grasp competency; Fail evaluation	Limited demonstration of competency; Pass with reservations; 4th yr Medical student level	Fair demonstration of competency; Pass; Junior resident level performance	Strong demonstration of competency; Senior resident level performance	Mastery of competency; performs at faculty level
0	1	2	3	4	5

Please rate clinical reasoning skills - NOTE NEW SCALE DEFINITIONS
(Question 16 of 18 - Mandatory)

Insufficient Observation	NOVICE: rigid adherence to taught rules or plans; no exercise of discretionary judgement if conflicting variables; detached attitude regarding outcome	ADVANCED BEGINNER: decisions made with limited situational awareness; thought process still mostly based on absolute rules; limited prioritization skills	COMPETENT: uses organizing priniciples in place of rigid rules; emotionally feels responsible for outcome of decisions; prioritizes information by relevance	PROFICIENT: intuitively sees problems based on experience and pattern recognition; perceives deviations from norm; holistically prioritizes factors	EXPERT: transcends reliance on rules; intuitively grasps nuances based on deep understanding; analyzes and adapts to uncertain situations effortlessly
0	1	2	3	4	5

Bottom line recommendation by training instructors *(Question 17 of 18 - Mandatory)*

REPEAT this training block prior to promotion to next level of responsibility	SATISFACTORY performance to merit training advancement
1	2

Comments (Please include at least one area for improvement): *(Question 18 of 18 - Mandatory)*

Review your answers in this evaluation. If you are satisfied with the evaluation, click the **SUBMIT** button below. Once submitted, evaluations are no longer available for you to make further changes.

Attachment 11

Nellis Air Force Base - Family Medicine Evaluation of Faculty by Resident

Dates of Activity:	
Activity:	Evaluation Preview
Evaluation Type:	Evaluation of Faculty by Resident

1. Please rate the faculty member's attributes in each category

Approachable and available *(Question 1 of 9)*

N/A	Poor	Below Average	Average	Above Average	Excellent
0	1	2	3	4	5

Open to others viewpoints *(Question 2 of 9)*

N/A	Poor	Below Average	Average	Above Average	Excellent
0	1	2	3	4	5

Teaching Ability *(Question 3 of 9)*

N/A	Poor	Below Average	Average	Above Average	Excellent
0	1	2	3	4	5

Clinical Knowledge *(Question 4 of 9)*

N/A	Poor	Below Average	Average	Above Average	Excellent
0	1	2	3	4	5

Enthusiasm for teaching *(Question 5 of 9)*

N/A	Poor	Below Average	Average	Above Average	Excellent
0	1	2	3	4	5

Scholarly Activity *(Question 6 of 9)*

N/A	Poor	Below Average	Average	Above Average	Excellent
0	1	2	3	4	5

Communication *(Question 7 of 9)*

N/A	Poor	Below Average	Average	Above Average	Excellent
0	1	2	3	4	5

Please comment about strengths and specific improvements to make this person a better teacher. Please be constructive.

Comments *(Question 8 of 9)*

Please rank the faculty member against other educators *(Question 9 of 9)*

N/A	Bottom 76-100%	51-75%	26-50%	11-25%	Top 10%
0	1	2	3	4	5

Attachment 12

Nellis Air Force Base - Family Medicine Program Evaluation by Resident

ANNUAL PROGRAM EVALUATION BY RESIDENTS

Do the faculty spend sufficient time TEACHING residents in your program? *(Question 1 of 19 - Mandatory, Confidential)*

N/A	Never	Sometimes	Always or Usually
○	○	○	○

Do the faculty spend sufficient time SUPERVISING the residents in your program? *(Question 2 of 19 - Mandatory, Confidential)*

N/A	Never	Sometimes	Always or Usually
○	○	○	○

Do your faculty members regularly participate in scheduled group learning sessions? *(Question 3 of 19 - Mandatory, Confidential)*

N/A	Never	Sometimes	Always or Usually
○	○	○	○

Do you review the written goals and objectives when starting most rotations? *(Question 4 of 19 - Mandatory, Confidential)*

N/A	Never	Sometimes	Always or Usually
○	○	○	○

Do you receive written or electronic feedback on your performance for each rotation and major assignment? *(Question 5 of 19 - Mandatory, Confidential)*

N/A	Never	Sometimes	Always or Usually
○	○	○	○

Are you able to review your performance evaluations in E-Value? *(Question 6 of 19 - Mandatory, Confidential)*

○ Yes ○ No

How often are you able to access, (either in print or electronic format), the clinical references materials that you need for patient care? *(Question 7 of 19 - Mandatory, Confidential)*

N/A	Never	Sometimes	Always or Usually
○	○	○	○

To what extent do trainees who are not part of your program (such as residents from other specialties, PA students) interfere with your education? *(Question 8 of 19 - Mandatory, Confidential)*

N/A	Not at All	Some Extent	A Great Extent
○	○	○	○

Are you able to speak freely about issues and problems in your program without fear of intimidation or retaliation? *(Question 9 of 19 - Mandatory, Confidential)*

N/A	Never	Sometimes	Always or Usually

Do you feel that your opinion or input is valued by the staff? *(Question 10 of 19 - Mandatory, Confidential)*

N/A	Never	Sometimes	Always or Usually

Does your residency promote clinical education as the core value when structuring training experiences, over scut work/service obligations? *(Question 11 of 19 - Mandatory, Confidential)*

N/A	Never	Sometimes	Always or Usually

Is your training at Nellis comparable or superior to what your peers are receiving in other programs? *(Question 12 of 19 - Mandatory, Confidential)*

Yes No Don't know

Would you apply to this program again if you had to reselect a residency location? *(Question 13 of 19 - Mandatory, Confidential)*

Yes No

Why would you select Nellis again (or select another location)? *(Question 14 of 19 - Mandatory, Confidential)*

Which department external to FMR provides the MOST EFFECTIVE teaching? Why did you select them? *(Question 15 of 19 - Mandatory, Confidential)*

Which department external to FMR provides the LEAST EFFECTIVE teaching? Why did you select them? *(Question 16 of 19 - Mandatory, Confidential)*

What is the best thing about our Nellis training program? *(Question 17 of 19 -*

Mandatory, Confidential)

What one thing would you change about Nellis FMR? *(Question 18 of 19 - Mandatory, Confidential)*

What other things do you want to comment on regarding our program? *(Question 19 of 19, Confidential)*

Review your answers in this evaluation. If you are satisfied with the evaluation, click the **SUBMIT** button below. Once submitted, evaluations are no longer available for you to make further changes.

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